



State of Tennessee
Health Services and Development Agency

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

Date: April 13, 2017

To: HSDA Members

From: Melanie M. Hill, Executive Director

Re: REMOVAL FROM CONSENT CALENDAR

CN1612-042-Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

The relocation of the applicant's principal office from Claiborne County to Jefferson County Tennessee. The estimated project cost is \$306,432.

This application was originally scheduled to be heard on the CONSENT CALENDAR but was removed from Consent consideration on April 10, 2017 due to the applicant's failure to disclose pertinent information regarding a second relocation of the principal (parent) agency during the application review process.

The applicant moved outside the county without CON approval and then after being notified a CON was required, filed a CON application to relocate the parent agency. During the CON application review process, the applicant moved the parent agency again, this time within the county, but failed to give notice to the TN Department of Health, the HSDA (that was reviewing its CON application), and according to Ms. Looney, its own corporate office. The applicant did manage to notify The Joint Commission of its new location because the new location was posted on The Joint Commission website.

Relocation within the same county is permissible because home health and hospice agencies are permitted by statute to relocate within the same county. However, the applicant had filed a letter of intent and given notice that it was relocating its parent agency from Tazewell when in fact it is now relocating from New Tazewell.

waller

APR 18 17 PM 4:22

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

April 18, 2017

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. CN1612-042

Dear Melanie:

Enclosed please find a revised timeline and additional information for the Tennessee Nursing Services of Morristown, Inc. CON project. Please let me know if you have any questions.

Sincerely,



Kim Harvey Looney

KHL:lag
Enclosures

Timeline for Tennessee Nursing Services of Morristown, Inc.

Background

Almost Family, Inc. acquired SunCrest Healthcare, Inc. in a stock transaction effective on December 7, 2013. Tennessee Nursing Services of Morristown, Inc. was a wholly owned subsidiary of SunCrest Healthcare, Inc. and is now wholly owned by Almost Family, Inc. Tennessee Nursing Services of Morristown, Inc. operated a home health agency ("HHA") with its parent office at 409 Cawood Road, Tazewell, Tennessee ("Tazewell"), and branch locations at 657 E Broadway Boulevard, Suite C, Jefferson City, Tennessee ("Jefferson City") and 105 West Stone Road, Suite 2D, Kingsport, Tennessee ("Kingsport"). SunCrest also operated a hospice at the Tazewell location, which was acquired by Almost Family, Inc. in the same transaction.

Almost Family determined that the operation of the HHA would be more efficient if, rather than the parent office being located in the smallest of the three cities with either a branch or a parent location, the parent office were moved to one of the branch locations, and the existing parent office closed. In order to better serve the existing patient population and reduce costs for the home health agency, management decided to close the Tazewell location and move the parent office to the Jefferson City location.

The following is a timeline of events that occurred after this decision was made:

January 2016

The HHA sent a letter to the Tennessee Department of Health, Division of Health Licensure and Regulation ("Licensure Division") on January 29, 2016 to notify the Licensure Division that it was relocating the parent office for its HHA from Tazewell to Jefferson City. The move date to Jefferson City would be effective March 1, 2016. After licensure approval, the HHA would request for CMS to delete the Jefferson City branch designation and relocate the parent office from Tazewell to Jefferson City. *Exhibit 1 Change of Address Notice.*

February 2016

On February 2, the HHA sent notice and the appropriate 855A form to Palmetto GBA, its fiscal intermediary for Medicare, to effect the change described above. *Exhibit 2: CMS 855A Change of Address.*

March 2016

Effective March 1, the HHA relocated its parent office for the HHA from Tazewell to Jefferson City. Also effective March 1, Palmetto GBA, on behalf of CMS, approved and completed the updates requested by the HHA. *Exhibit 3: Approval of Change of Address from CMS.*

April 2016

Almost Family, Inc. filed a request with the Licensure Division to delete the branch office for Tazewell. *Exhibit 4: Branch Deletion.*

June 2016

On June 21, the HHA received a letter from the Licensure Division which acknowledged the address change of its parent office from Tazewell to Jefferson City, effective March 1, 2016. The letter also stated the Licensure Division would forward confirmation of acknowledgment to Palmetto GBA. *Exhibit 5: Change of Address Approval.* The Licensure Division included a new license with the address

updated to Jefferson City. Exhibit 6: Jefferson City License. Neither the Licensure Division or Almost Family, Inc. were aware that this relocation required a Certificate of Need ("CON") from the Tennessee Health Services and Development Agency ("HSDA") as a result of the change of the parent office from one county to another. Prior to Almost Family's acquisition of SunCrest, it had no operations in Tennessee. To the best of Almost Family's knowledge, none of the other states in which it operates require a CON to relocate a parent office provided the new location is also located within the service area of the agency.

September 2016

The HHA received correspondence dated September 27, 2016 which stated upon "further review of your file . . . the change of address is hereby rescinded". Exhibit 7: Approval Rescinded by Licensure Division. The Licensure Division stated a CON was required because the relocation of the parent office was a move to a different county. This letter was not sent until several months after the change had been implemented and approved by both the state Licensure Division and Medicare. The person at licensure who processed Almost Family's application did not realize that this move required a CON. The Licensure Division did not update or issue an amended license.

October 2016

After receiving the revocation letter, personnel at the HHA called the corporate office of Almost Family, Inc. to discuss the situation. Almost Family, Inc. then consulted with attorney Kim Looney at Waller Lansden about the need for a CON in this situation, and was informed that a CON was required. Ms. Looney consulted with the HSDA, and was advised that the HHA should revert to using the Tazewell office as its parent office, and file a CON Application and pay the applicable CON filing fee, for a change of location of the parent office to a different county.

The HHA was able to re-establish the parent office in the former location at Tazewell six months after it had moved. The location was still under lease by Almost Family and used for its licensed hospice agency. Exhibit 8: Hospice License. The hospice continued to operate at the Tazewell location, but was considering options to move to a smaller space, which would cost less money, and not have excess capacity.

December 2016

On December 15, the HHA filed a CON Application to take steps to comply with the HSDA's directive. At the time of filing, the HHA and hospice were both operating out of Tazewell.

January 2017

In a supplemental response to the HSDA dated January 25, 2017, Kim Looney, on behalf of the HHA, stated the HHA was using Tazewell as its parent office. The lease for Tazewell was still in effect at that time.

As discussed below, subsequent internal audits revealed that the HHA relocated to 903 Main Street, New Tazewell (New Tazewell) with the Hospice on January 3, 2017, without either the knowledge or the approval of the corporate office, which was coordinating the CON.

March 2017

On March 23, Ms. Hill requested additional information on when the HHA reverted to using the Tazewell office as its parent location. On March 26, 2017 Kim Looney contacted Almost Family, Inc. and asked for an exact timeline of move dates. At that time, the corporate office was unaware of the subsequent move of the HHA. The HHA had a month-to-month lease at Tazewell, and the corporate

office was planning to continue to operate at that location until the CON could be heard. To pinpoint exact dates, Almost Family, Inc. conducted an internal audit of the Tazewell records. Almost Family, Inc. interviewed the HHA staff, hospice staff, and landlord. It was at that time that Margaret Royer, a paralegal in the corporate office, discovered that the HHA had moved with the hospice to the new location for the hospice on January 3, 2017. The month-to-month lease for Tazewell subsequently lapsed February 1, 2017. Shortly after the move, the hospice updated its license as to the new location with the State of Tennessee. Exhibit 10: New Tazewell Hospice License. The Hospice and Home Health Agency effectively had two (2) concurrent locations, at Tazewell and New Tazewell, through February 1, 2017.

The personnel in the corporate office for Almost Family were unaware that this change had occurred for the HHA. In looking at the records of the person who coordinates the real estate for Almost Family, there was no indication that the HHA had changed locations. The rent check continued to go to the same landlord at the Tazewell location. Both properties are owned by the same landlord, so nothing triggered a change as far as the payment of rent was concerned. Almost Family has a process that is supposed to be used when either a HHA or a hospice changes locations; and that is a corporate-wide notice is to be sent. In this situation, a notice was sent on January 4, 2017, that effective on January 3, 2017, the office of the hospice was relocated from Tazewell to New Tazewell, approximately 1.6 miles away. There was no such notice sent for the HHA. Exhibit 11: Email to Corporate Office for Change of Hospice Location.

Further investigation has also revealed that the HHA has not updated Medicare with a form 855 Change of Address filing for the relocation back to the Tazewell location because the HHA did not receive an amended license with the Tazewell address from the Licensure Division. Thus, the subsequent move to the New Tazewell location, which was discovered a couple of weeks ago, has also not been reported.

The license and Medicare information will be correct once the move to Jefferson City is approved through the CON process, and the appropriate notifications are made.



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January 29, 2016

Bureau of Health Licensure and Regulation
Division of Health Care Facilities
665 Mainstream Drive
2nd Floor
Nashville, TN 37243

RE: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
License # 93
Moving Operations

Dear Sir or Madam:

Effective March 1, 2016, the parent location of Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health, currently located at 409 Cawood Road, Tazewell, TN will be moving and consolidating its operations in the Jefferson City, TN branch. The new address will be as follows:

657 Broadway
Suite C
Jefferson City, TN 37760-4949

I have included a copy of the lease and the current state license for your review.

We will be notifying CMS to delete the Jefferson City branch designation and move the parent agency to this location.

If you need further information, please contact Laura Jo Bland at LauraJoBland@almostfamily.com.

Sincerely,

P. Todd Lyles
Sr. Vice President

Enclosures

AMENDMENT OF LEASE

This AMENDMENT OF LEASE is made as of the 4th day of March, 2015 by and between Aqueel Kouser (hereinafter referred to as "Lessor") and Tennessee Nursing Services of Morristown, Inc., a Tennessee corporation d/b/a SunCrest Home Health, Hospice and Private Duty (hereinafter referred to as "Lessee").

RECITALS:

WHEREAS, Lessor and Lessee are parties to a certain Lease ("Lease"), dated October 3rd, 2014, and pursuant to which Lessor leased to Lessee and Lessee leased from Lessor the building located at 657 Broadway, Suite B, Jefferson City, Tennessee, and which Lease expires on October 15, 2017, and

WHEREAS, the Parties hereto wish to amend the Lease to correct the legal address of the leased premises:

NOW, THEREFORE, in consideration of the foregoing recitals and for other good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree the Premises is hereby revised to be 657 Broadway, Suite C, and Jefferson City, Tennessee.

EXCEPT as expressly provided herein, all other terms and conditions of the Lease Agreement remain unchanged and are hereby ratified and confirmed.

IN WITNESS WHEREOF, the parties hereto have signed and executed Amendment to Lease Agreement on the day and year first written above.

WITNESS:



Aqueel Kouser



WITNESS:



Tennessee Nursing Services of Morristown, Inc.
Todd Lyles, Sr. Vice President



Board for Licensing Health Care Facilities

State of



Tennessee

License No. 0000000093

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

_____ TENNESSEE NURSING SERVICE OF MORRISTOWN, INC.

to conduct and maintain a

Home Care Organization

SUNCREST HOME HEALTH

Located at 409 CAWOOD ROAD, TAZEWELL

County of CLAIRBORNE

Tennessee

This license shall expire

NOVEMBER 02

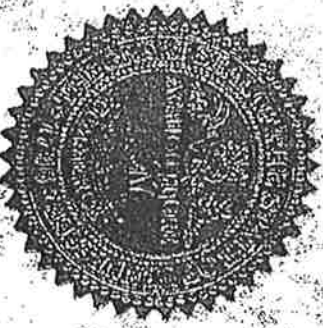
, 2016

, and is subject

to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 8TH day of SEPTEMBER, 2015.

SKILLED NURSING
PHYSICAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL SERVICES
HOME HEALTH AID SERVICES
HOME HEALTH AGENCY
OTHER SPECIALTY
HOMEMAKERS SERVICES
OCCUPATIONAL THERAPY



James J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

Cheryl J. Davis

COMMISSIONER



Almost Family, Inc.

9510 Ormsby Station Road, Suite 300

Louisville, KY 40223

502.891.1000

February 2, 2016

Palmetto GBA

Part A Provider Enrollment (AG-331)

2300 Springdale Drive, Building One

Camden, SC 29020-1728

RE: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
Move Parent 44-7528 and Close Branch Number 44Q7528 002

Dear Sir or Madam:

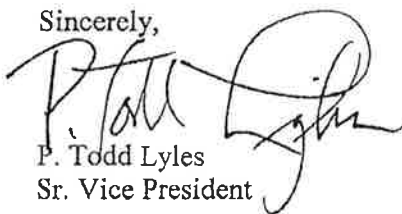
Enclosed please find two (2) CMS855A forms: (1) for an address change to Parent 44-7528 and (2) close Branch Number 44Q7528 002. Effective March 1, 2016, the parent of Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health, currently located at 409 Cawood Road, Tazewell, TN will be moving. Their new address will be as follows:

657 Broadway
Suite C
Jefferson City, TN 37760-4949

The Branch Number 44Q7528 002 should be deleted effective February 29, 2016.

If you need further information, please contact Laura Jo Bland at
LauraJoBland@almostfamily.com.

Sincerely,



P. Todd Lyles
Sr. Vice President

Enclosure

A/B MAC JURISDICTION M
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice



PALMETTO GBA
A CECILIAN GROUP COMPANY

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March 21, 2016

ATTN: Patrick Lyles
Tennessee Nursing Services of Morristown, Inc.
9510 Ormsby Station Rd, Suite 300
Louisville, KY 40223-5016

DCN: 16036C22100232

We have completed the requested updates to your provider information for the following entity.

Legal Business Name: Tennessee Nursing Services of Morristown, Inc.
DBA: Suncrest Home Health
Provider Number: 44-7528
NPI(s): 1396717807

The following information was updated.

- ☐ Name Change
- ☐ Structure Change
- ☐ Practice Special Payment Address
- ☐ Management Personnel Section 6 Addition
- ☐ Management Personnel Section 6 Deletion
- ☐ Organization Interest/Managing Control Section 5 Addition
- ☐ Organization Interest/Managing Control Section 5 Deletion
- ☐ Telephone Number
- ☐ Fax Number
- ☐ Branch Location Change
- ☒ Branch Location Deletion SunCrest Home Health 409 Cawood Rd. Tazwell, TN 37879-3026 effective 03/01/2016.
- ☐ OPT Extension Site
- ☐ Authorized/Delegated Official Addition
- ☐ Authorized/Delegated Official Deletion
- ☐ Electronic Funds Transfer (EFT) – Our Finance Department will complete the final steps to change your EFT banking information. Please expect a minimum of two weeks from the date of this letter for completion. You may contact 866-749-4301 with questions specific to EFT.
- ☐ Practice Location Name Update - The practice location name entered into the Provider Enrollment, Chain and Ownership System shall reflect the legal business name of the provider.
- ☒ Parent Location Change to 657 Broadway, Suite C; Jefferson City, TN 37760-4949 effective 03/01/2016.

Please verify the accuracy of your information.

Change of Address and Branch/Unit Additions

Please note that this approval letter does not signify CMS's approval of the changed or new location. Only the CMS Regional Office can approve the change or addition. Written notification will be made once the approval is granted.

You are required to submit updates and changes to your enrollment information in accordance with specified timeframes pursuant to 42 CFR §424.516. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: www.cms.hhs.gov/MedicareProviderSupEnroll.

Providers and suppliers enrolled in Medicare are required to ensure strict compliance with Medicare regulations, including payment policy and coverage guidelines. CMS conducts numerous types of compliance reviews to ensure providers and suppliers are meeting this obligation. Please visit the Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for further information about regulations and compliance reviews, as well as Continuing Medical Education (CME) courses for qualified providers.

Additional information about the Medicare program, including billing, fee schedules, and Medicare policies and regulations can be found at our Web site at:
<http://www.palmettogba.com/medicare>

Or the Centers for Medicare & Medicaid Services (CMS) Web site at
<http://www.cms.hhs.gov/home/medicare.asp>.

A copy of this letter along with the CMS Form 855A has been forwarded to your state survey office. Please verify the accuracy of your enrollment information. If you have any questions, you may contact our Provider Contact Center at (855) 696-0705.

Sincerely,

Nikoa Jefferson

Provider Enrollment Analyst
Division of Provider Enrollment
Palmetto GBA

cc: State Survey Agency Contact: Marsha Neuenschwander, Department of Health



Almost Family, Inc.

9510 Ormsby Station Road, Suite 300
Louisville, KY 40223
502.891.1000 Fax: 502.891.8067

APR 18 '17 PM 4:22

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April 26, 2016

Bureau of Health Licensure and Regulation
Division of Health Care Facilities
665 Mainstream Drive
2nd Floor
Nashville, TN 37243

RE: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
License # 93
Deleting Branch ID

Dear Sir or Madam:

Effective March 1, 2016, Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health requests that Branch 44Q7528002 be deleted. We have notified CMS regarding the deletion of the branch as well. If you need further information, please contact me at LauraJoBland@almostfamily.com.

Sincerely,

Laura Jo Bland
Compliance Coordinator



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June 21, 2016

Ms. Cristy West
Suncrest Home Health
657 Broadway, Ste C
Jefferson City TN 37760-4949

RE: CMS Provider Number 44-7528

Dear Ms. West,

This is to acknowledge the address change of your parent office from 409 Cawood Lane, Tazewell, TN 37879, to 657 Broadway, Ste C, Jefferson City TN 37760-4949, effective March 01, 2016.

A copy of this acknowledgment is also being sent to your fiscal intermediary Palmetto GBA.

Should you have any questions concerning this matter, please contact the East Tennessee Regional Office at (865) 594-9396.

Sincerely,

A handwritten signature in cursive script that reads 'Tamra Turberville' followed by a stylized monogram.

Tamra Turberville, RN
Regional Administrator

TT/kg

Board for Licensing Health Care Facilities



State of Tennessee

License No. 0000000083

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

_____ to conduct and maintain a

Home Care Organization _____ SUNCREST HOME HEALTH

Located at _____ 657 BROADWAY BLVD., SUITE C, JEFFERSON CTY

County of _____ JEFFERSON _____, Tennessee.

This license shall expire _____ NOVEMBER 02 _____, 2017, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 15TH *day of* SEPTEMBER, 2016.

In the Distinct Category(ies) of:

SKILLED NURSING
PHYSICAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL SERVICES
HOME HEALTH AID SERVICES
HOME HEALTH AGENCY
OTHER SPECIALTY
HOMEMAKERS SERVICES
OCCUPATIONAL THERAPY



By

James J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

James J. Davis, MPH

COMMISSIONER



September 27, 2016

Christy West
Tennessee Nursing Service of Morristown d/b/a Suncrest Home Health
657 Broadway, Suite C
Jefferson City, TN 37760-4949

Facility Type: Home Health Agency
License Number: 93

Dear Administrator:

On June 22, 2016, Office of Health Care Facilities (OHCF) sent you a letter acknowledging a facility address change for Suncrest Home Health from 409 Cawood Road, Tazwell, Tennessee 37879-3026 (Claiborne County) to 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949 (Jefferson County) with an effective date of March 1, 2016.

After further review of your file, as of September 27, 2016, the change of address is hereby rescinded. This is due to your facility not obtaining prior approval from Health Services and Development Agency (HSDA). In accordance with *T.C.A. 68-11-1607(a)(5)* "The relocation of the principal office of a home health agency or hospice within the same county shall not require a certificate of need.", a move of the parent office to a different county would require an approved Certificate of Need.

Please contact Alecia Craighead at HSDA at 615-741-2364 concerning the relocation of the parent office of Suncrest Home Health.

Once OHCF receives notification that HSDA has approved the relocation of the parent office of Suncrest Home Health a change of address for Suncrest Home Health will be completed with another wall certificate issued to reflect the new address.

Sincerely,

A handwritten signature in black ink that reads 'Ann R. Reed'.

Ann R. Reed, RN, BSN, MBA
Director of Licensure and the Board for Licensing Health Care Facilities
Office of Health Care Facilities
Licensure Unit

cc: East Tennessee Regional Office
Melanie Hill, Health Services and Development Agency
Dee Willis, Information Technology Services Division

Board for Licensing Health Care Facilities

State of Tennessee



License No. 0000000362

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

to conduct and maintain a

Facility

SUNCREST HOSPICE

Located at

409 CAWOOD ROAD, TAZEWELL

County of

CLAIBORNE

, Tennessee.

This license shall expire

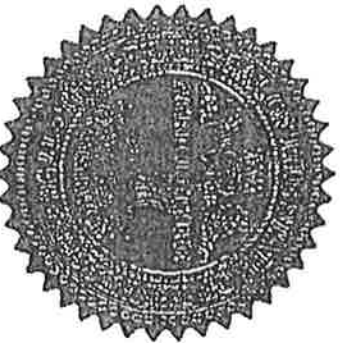
NOVEMBER 03

, 2017

, and is subject

to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued hereunder.

We, the Tennessee Secretary, do hereunto set our hand and seal of the State this 15TH day of SEPTEMBER, 2016.



By Lucius J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By Cheryl D. Davis

COMMISSIONER

LEASE AGREEMENT

This Lease Agreement ("Lease") is made and effective this 09th day of September, 2016 ("Effective Date"), by and between Roger A. Ball & Carroll Rose, dba: Rockwood Shopping Center, a Tennessee partnership having its principal place of business at 1894 HWY 25E, Tazewell, TN 37879 ("Landlord") and Tennessee Nursing Services of Morristown, Inc., having its principal place of business at 9510 Ormsby Station Rd, Suite 300 Louisville, KY 40223 ("Tenant").

RECITALS

WHEREAS, Landlord is the owner of land and improvements located at 903 Main Street, New Tazewell, TN 37825 (the "Building"); and

WHEREAS, Landlord desires to lease a portion of the Building consisting of approximately 2,560 square feet (the "Premises"), which is shown on the floor plan attached hereto as Exhibit "A"; and

WHEREAS, Landlord desires to lease the Premises to Tenant, and Tenant desires to lease the Premises from Landlord for the Term, at the rental and upon the covenants, conditions and provisions herein set forth.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and other good and valuable consideration, it is agreed:

1. **Term.** This Lease shall be for a term (hereinafter referred to as the "Initial Term") (a) commencing on (the "Commencement Date") which is the later to occur of (i) December 1, 2016 (the "Target Date"), or (ii) days following the date on which Landlord has substantially completed the Work (pursuant to and as defined in Section 39 and Exhibit B hereof) and tendered possession of the Premises to Tenant, and (b) terminating on the day (the "Termination Date") immediately preceding the sixty-two (62) month anniversary of the first day of the first full calendar month during the Initial Term, at 11:59 p.m., local time. Tenant shall have access to space 30 days prior to Commencement Date to install phone and data lines. After the commencement of the Initial Term, Landlord and Tenant shall execute a commencement letter to be provided by Tenant. Between the Effective Date and the Commencement Date, all of the provisions of this Lease shall be in full force and effect except for Tenant's obligation to pay Rent.
2. **Renewal.** Tenant shall have the option to renew this Lease for One (1) renewal term of three (3) years each (each a "Renewal Term"). Tenant shall provide Landlord with written notice of its intent to renew this Lease at least ninety (90) days prior to the expiration of the Initial Term (or the applicable Renewal Term then in effect). Otherwise, Tenant shall forfeit its right to renew this Lease and this Lease shall terminate at the conclusion of the Initial Term (or the applicable Renewal Term then in effect), unless otherwise agreed to by Landlord in writing. Any renewal of this Lease shall be upon the same terms and conditions as are set forth herein. The Initial Term, together with any Renewal Terms shall be referred to herein as the "Term".

3. **Expansion.** Tenant shall have the right of first refusal ("ROFR") to expand and/or lease spaces contiguous to the Premises in the Building ("ROFR Space"), should they become available. Landlord shall notify Tenant in writing (the "ROFR Notice") if Landlord elects to lease all or any part of the ROFR Space and the ROFR Notice shall provide the business terms of the offer (i.e. rent, location of premises, size of premises, length of term, improvement allowance, if any). Tenant shall reply within fifteen (15) days of receipt of such ROFR Notice, either exercising or foregoing such right of refusal. If Tenant properly exercises its right of first refusal in the manner and within the time period specified herein, then Landlord and Tenant shall, within thirty (30) days after Tenant delivers to Landlord notice of its election, enter into a written amendment delivered by Landlord to Tenant within five (5) business days after Tenant delivers to Landlord notice of Tenant's election, modifying and supplementing this Lease with respect to the ROFR Space based on the business terms contained in the ROFR Notice. Except for the rent, location, and size of the ROFR Space, and the improvement allowance, if any, all other terms and conditions of this Lease shall apply to the ROFR Space. If Tenant foregoes its rights hereunder, Landlord shall be free to lease the ROFR Space identified in the ROFR Notice thereafter with a third party on substantially the same terms as contained in the ROFR Notice.

4. **Rental.**

- a. **Basic Rent.** Tenant shall pay to Landlord during the Initial Term, Basic Rent (herein so called) in the amount of:

Period		Rentable Square Footage	Annual Rent Per Square Foot	Annual Rent	Monthly Installment of Rent
from	through				
12/1/2016	1/31/2017	2,560	\$0.00	\$0.00	\$0.00
2/1/2017	1/31/2022	2,560	\$9.25	\$23,680.00	\$1,973.33

due in advance on or before the fifth (5th) day of each calendar month during the Lease Term. The Rent for any partial calendar months included in the Lease Term shall be prorated on a daily basis. Except as otherwise expressly provided in this Section 4, the foregoing Rent is intended to be, and is, a gross rent and Tenant shall not be responsible for any additional payments or charges, including without limitation, for taxes, insurance, utilities, or operating expenses for the Building or common areas.

5. **Security Deposit.** Tenant shall not be required to deposit a Security Deposit to Landlord.
6. **Use.** Tenant shall use the Premises for office purposes, including operating a home health agency and all other uses incidental thereto. In addition, Tenant may also provide minor medical care and services within the Premises. Further, Tenant shall conduct its business and control its agents, employees, invitees and visitors in such manner as not to create any nuisance, or interfere with, or unlawfully or unreasonably disturb any other tenant in the Building. Tenant shall not obstruct or use the sidewalks, entries, passages, vestibules, halls, elevators, or stairways of the Building for any other purpose than ingress and egress to and from the Premises, or throw or sweep or put anything out of the windows or doors, or in the passage or corridors of the Building. Landlord, at Landlord's expense, shall be responsible for obtaining the Certificate of Occupancy on the entire Premises, in Tenant's f/b/o name as listed in the first paragraph of this Lease, prior to the Commencement Date of this Lease.

7. **Hazardous Materials.** Tenant will not cause or permit any Hazardous Materials (defined below) to be brought upon, kept or used in or about the Premises or the Building; provided, that, if certain Hazardous Materials are necessary for Tenant's use as set forth in Section 6 above, Tenant may utilize, store and/or dispose of same upon written notice to Landlord if (i) such Hazardous Materials are used, kept and stored in a manner which complies with all applicable federal, state and local laws, ordinances, rules and regulations regulating such Hazardous Materials; and (ii) such presence and use of Hazardous Materials will be in quantities and applications normally found in general office use or the practice of Tenant's medical specialty; Tenant hereby agrees to indemnify, defend and hold Landlord free and harmless from and against any and all claims, judgments, damages, penalties, fines, costs, liabilities and losses (including, without limitation, diminution in value of the Premises and the Building, damages for the loss or restriction of use of space or of any amenity of the Premises and the Building, and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees) that may arise during or after the Term of this Lease as a result of Tenant's breach of the covenants and obligations set forth in this section or the presence of Hazardous Materials on, in or about the Premises or the Building caused or permitted by the acts or omissions of Tenant, its employees, agents, contractors, licensees, invitees, assignees or subtenants. This indemnification by Tenant of Landlord includes, without limitation, any and all reasonable costs incurred in connection with any investigation of site conditions or any clean up, remedial, removal or restoration work required by any federal, state or local governmental agency or political subdivision thereof because of the presence or suspected presence of such Hazardous Material in, on or about the Premises, the Building or the soil or groundwater on or under the Building to the extent caused by Tenant. If any state, federal or local governmental agency or political subdivision thereof imposes a lien on the Premises or the Building because of the presence or suspected presence of such Hazardous Material in, on or about the Premises or the Building, Tenant will cause such lien to be removed at Tenant's sole cost and expense. The provisions of this section will survive the expiration or termination of this Lease. As used herein, the term "Hazardous Materials" will mean and include any and all hazardous substances, any hazardous wastes or any pollutants or contaminants defined as such in or regulated by: (i) the Resource Conservation and Recovery Act of 1976, 42 U.S.C. 6901 *et seq.*, (ii) the Comprehensive Environmental Response Compensation and Liability Act of 1980, 42 U.S.C. 9601 *et seq.*, (iii) the Federal Water Pollution Control Act, 33 U.S.C. 1251 *et seq.*, as amended; (iv) the Clean Air Act, 42 U.S.C. 7401 *et seq.*, (v) the Toxic Substances Control Act, 15 U.S.C. 2501 *et seq.*, or (vi) any amendments or statutory successors to the foregoing statutes and any now or hereafter existing federal, state or local statute, law, ordinance, code, rule, regulation, order or decree regulating, relating to or imposing liability or standards of conduct concerning any hazardous, toxic or dangerous waste, substance or material, as presently or hereafter in effect during the Term of the Lease.
8. **Sublease and Assignment.** Tenant shall not sublease all or any part of the Premises, or assign this Lease in whole or in part, without Landlord's consent, which consent shall not be unreasonably withheld or delayed. Landlord shall consent or withhold such consent by written notice to Tenant within fifteen (15) days of Tenant's written request for Landlord's consent. If Landlord fails to respond to Tenant's request within such 15-day period, Landlord shall be deemed to have consented to such assignment or subletting.

Notwithstanding anything to the contrary in this section, the initial named Tenant herein may, without Landlord's consent, assign this Lease or sublease all or part of the Premises to any party (herein referred to as a "Tenant Affiliate") which directly or indirectly: (i) wholly owns or

controls Tenant, (ii) is wholly owned or controlled by Tenant, (iii) is under common ownership or control with Tenant, or (iv) into which Tenant or any of the foregoing parties is merged, consolidated or reorganized, or to which all or substantially all of Tenant's assets or any such other party's assets are sold.

9. Repairs.

- a. Landlord's Obligations. Landlord agrees at Landlord's sole cost and expense: (a) to properly maintain and make all necessary repairs and replacements to the roof (including roof coverings and roof skin), gutters, downspouts, foundation, floor slab, exterior walls (including the storefront), demising walls, door and window frames, and the structural portions of the Premises and the Building of which the Premises forms a part, and otherwise to keep the Premises in a watertight condition; (b) to make all repairs and replacements necessary to satisfy Landlord's warranties; (c) to make all necessary repairs and replacements to the electrical, plumbing, mechanical systems and devices serving the Premises and Building, including all water, sewer, gas, electrical and public utility lines and connections of the Building up to the point that they become exposed within the Premises if the same exclusively serve the Premises (and within the Premises to the extent the same run through the Premises but do not exclusively serve it); (d) to make all necessary repairs and replacements to the sprinkler, fire alarm and other life safety systems serving the Premises (whether interior or exterior), and to perform all monitoring and pay all fees associated therewith; (e) to repair, maintain, and replace the heating, ventilating and air conditioning system which provides service to the Premises; (f) to secure any vacant space adjacent to the Premises and ensure that the walls and roof of the Premises are maintained so as to prevent ease of entry by unauthorized persons; (g) to keep and maintain in good repair and working order, and make all necessary repairs and replacements to all common areas, landscaping, parking facilities, paved areas and drives, and (h) to make all repairs and replacements to the Premises necessitated by Landlord's failure to perform its obligations under this Section 9(a). Landlord will also paint (if a paintable surface) and otherwise maintain the exterior of the Premises and the Building in which the Premises are located. Further, Landlord will also keep and maintain in good repair the walls, ceilings, glass, windows, doors, floors, light fixtures, and roof. Landlord further agrees to make all repairs and replacements to the Building to keep and maintain the same as a first class Building in good order, condition and repair. Landlord agrees that such repairs and replacements will be done promptly in a good and workmanlike manner and that it will repair any and all damage which may result from its failure to make such repairs or replacements. Except if necessitated by Tenant's specific use of the Premises, any addition, alteration or improvement, structural or otherwise, to or on the Premises, and any installation or modification of any equipment or systems serving the Premises, which may be necessary or required by reason of any law, rule, regulation or order promulgated by a governmental authority immediately shall be made by, and at the cost and expense of, Landlord. Any work required by this paragraph shall be made in accordance with plans and specifications approved by Tenant and all work shall be completed in a manner which would not unreasonably interfere with Tenant's conduct of its business at

the Premises. To the extent that the Premises are rendered totally or partially untenable, as a result of Landlord exercising its rights under this Section 9(a), Rent shall be proportionately abated until Landlord has completed such repair, reconstruction or restoration.

- b. Tenant's Obligations. Other than the maintenance and repair to be performed by Landlord as set forth above or otherwise in the Lease, Tenant, at its sole cost and expense, will keep and maintain in good repair and working order and make all repairs to and perform necessary maintenance within and upon the Premises, including any systems and devices in the Premises that serve the Premises and are not the Building's base systems or devices (including, without limitation, telecommunications and computer systems), and all parts and appurtenances thereof, which are required in the normal maintenance, repair and operation of the Premises.
10. Alterations and Improvements. Tenant, at Tenant's expense, shall have the right, upon obtaining the consent of the Landlord (which consent will not be unreasonably withheld), to alter, remodel, and make additions, improvements and replacements of and to all or any part of the Premises from time to time as Tenant may deem desirable, provided the same are made in a workmanlike manner and utilizing good quality materials. All plans, designs or models for any such alteration, redecorating, additions, improvements or replacements must be submitted for review and approval of Landlord (which approval will not be unreasonably withheld) prior to the commencement of any such work or build-out. Tenant shall have the right to place and install personal property, trade fixtures, equipment and other temporary installations in and upon the Premises. All personal property, equipment, machinery, trade fixtures and temporary installations, whether acquired by Tenant at the commencement of the Lease Term or placed or installed on the Premises by Tenant thereafter, shall remain Tenant's property. Tenant shall have the right to remove the same at any time during the Term of this Lease provided that all damage to the Premises caused by such removal shall be repaired by Tenant at Tenant's expense.
11. Property Tax. Landlord shall pay, prior to delinquency, all general real estate taxes and installments of special assessments coming due during the Lease Term on the Building of which the Premises are a part, and all personal property taxes with respect to Landlord's personal property, if any, on the Premises. Tenant shall be responsible for taxes or assessments with regard to Tenant's personal property, if any, on the Premises.
12. Insurance.
 - a. Tenant will, at its expense, maintain in full force and effect at all times during the Term of this Lease commercial general public liability insurance with respect to the Premises, with a single limit of liability of \$1,000,000 for each occurrence, subject to an aggregate limit of \$3,000,000. Each policy of insurance maintained by Tenant will be issued by an insurance company acceptable to Landlord, and provide that such insurance will not be canceled unless thirty (30) days prior written notice is given to Landlord. The policies of insurance required to be maintained by Tenant hereunder, or acceptable certificates thereof, will be delivered to Landlord on or before the Commencement Date and at least thirty (30) days prior to the expiration date of any policy then in effect.

- b. Landlord will, at its expense, maintain in full force and effect at all times during the Term of this Lease: (a) fire and extended coverage insurance covering real and personal property in connection with the Building and the Premises (including the leasehold improvements in the Premises, but excluding Tenant's personal property and equipment); and (b) commercial general public liability insurance covering the Building, with a single limit of liability of \$1,000,000 for each occurrence, subject to an aggregate limit of \$3,000,000. Landlord's liability insurance shall name Tenant as an additional insured. Certificates evidencing all such insurance shall be delivered to Tenant from time to time upon Tenant's request.

13. **Indemnification.** Tenant shall indemnify Landlord against any expenses, loss, cost, damage, claim, action or liability paid, suffered or incurred as a result of any breach by Tenant, Tenant's agents, servants, employees, visitors or licensees of any covenant or condition of this Lease, or as a result of activities occurring within the Premises, unless caused by the gross negligence or willful misconduct of Landlord, its agents, servants, employees, customers, visitors or licensees.

Landlord shall indemnify Tenant against any expenses, loss, cost, damage, claim, action, or liability paid, suffered or incurred as a result of any breach by Landlord, Landlord's agents, servants, employees, customers, visitors or licensees of any representation, warranty, covenant or condition of this Lease or as a result of activities occurring in the Building (other than the Premises) or the common areas, unless caused by the gross negligence or willful misconduct of Tenant, its agents, servants, employees, customers, visitors or licensees.

14. **Utilities/Services.** Tenant shall be responsible for all charges for water, sewer, garbage, gas, electricity, janitorial and other services and utilities used by Tenant on the Premises during the Term of this Lease unless otherwise designated in the Lease. Landlord shall supply services of a type and manner commensurate with the standards of other similar buildings in the Tazewell area, including without limitation: (i) electricity suitable for the use of the Premises; (ii) cold and hot water to the space, the common area restroom, and break room, (iii) heating and air-conditioning (during those respective seasons of the year in which they are necessary) for the comfortable use and occupancy of the Premises, between 7:00 o'clock a.m. and 6:00 o'clock p.m., Monday through Friday and between 8:00 o'clock a.m. and 12:00 o'clock p.m., Saturday, (iv) pest control. Burglar alarm and alarm monitoring to be provided by Tenant at Tenant's expense.

Tenant acknowledges that the Premises are designed to provide standard office use electrical facilities and standard office lighting. Tenant shall not use any equipment or device that utilizes excessive electrical energy or which may, in Landlord's reasonable opinion, overload the wiring or interfere with electrical services to other tenants.

15. **Common Area Maintenance.** Landlord shall be responsible for expenses incurred in connection with maintenance of the common areas of the Building. Such expenses shall include water supplied to the Building, cleaning services, waste collection services, sewer, burglar alarm and monitoring services, lawn services, elevator services and other supplies or services which Tenant receives the benefit of. Tenant will reimburse Landlord for Tenant's Proportionate Share of the reasonable costs of maintaining the Common Areas incurred by Landlord during the Term in an amount not to exceed \$0.60 per square foot.

16. Signs. Landlord shall provide to Tenant, at Landlord's expense, Tenant's name in the directory signage in the lobby of the Building and building standard suite entry signage. Tenant may install on the Premises, at Tenant's expense, its standard signage. Tenant may also install, at Tenant's expense, a tenant panel, on the monument signage [located in front of the Building]. Tenant may also install, at Tenant's expense, Tenant's logo, hours of operation and emergency contact information on the door or glass of the Premises.
17. Entry. Landlord shall use best business effort to notify Tenant 24 hours in advance of entry to Premises. In the event Landlord cannot provide 24 hours advance notice despite its best efforts, it shall nonetheless notify Tenant of entry within 24 hours thereafter. Nothing herein shall waive, modify, or obviate Landlord's obligations pursuant to Section 37.
18. Parking. During the Term of this Lease, Landlord will make available to Tenant a minimum of five (5) parking spots per thousand square feet of rented space, of which Tenant shall have the non-exclusive use in common with Landlord, other tenants of the Building, their guests and invitees, of the non-reserved common automobile parking areas, driveways, and footways, subject to rules and regulations for the use thereof as prescribed from time to time by Landlord. Landlord reserves the right to designate parking areas within the Building or in reasonable proximity thereto, for Tenant and Tenant's agents and employees. There will be no additional charges for parking. If card access is required, Landlord shall provide cards at Landlord's expense.
19. Building Rules. The Tenant agrees to comply with all laws, ordinances, orders, rules and regulation (state, federal, municipal and other agencies or bodies having any jurisdiction thereof) relating to the use, condition or occupancy of the Premises. Except to the extent that the rules may conflict with this Lease, the Tenant will comply with the reasonable rules of the Building adopted and altered (so long as such rules are applied consistently to all tenants within the Building) by the Landlord from time to time for the safety, care and cleanliness of the Premises and Building and for preservation of good order therein, copies of which will be sent by the Landlord to the Tenant in writing, if so requested.
20. Damage and Destruction. If the Premises, common areas or any part thereof or any appurtenance thereto is so damaged by fire, casualty or structural defects that the same cannot be used for Tenant's purposes, the Tenant shall have the right, within ninety (90) days following damage, to elect by notice to Landlord to terminate this Lease as of the date of such damage. In the event of minor damage to any part of the Premises or common areas, and if such damage does not render the Premises unusable for Tenant's purposes, Landlord shall promptly repair such damage at the cost of the Landlord. In making the repairs called for in this paragraph, Landlord shall not be liable for any delays, whether resulting from strikes, governmental restrictions, inability to obtain necessary materials or labor or other matters which may cause delay to such repairs, unless such delays are caused by Landlord. Tenant shall be relieved from paying rent and other charges during any portion of the Lease Term that the Premises, or any portion thereof, are unusable or unfit for occupancy, or use, in whole or in part, for Tenant's purposes. Rentals and other charges paid in advance for any such periods shall be credited on the next ensuing payments, if any, but if no further payments are to be made, any such advance payments shall be refunded to Tenant. The provisions of this paragraph extend not only to the matters aforesaid, but also to any occurrence which is beyond Tenant's reasonable control and which renders the

Premises, common areas, or any appurtenance thereto, unusable or unfit for occupancy or use, in whole or in part, for Tenant's purposes.

Notwithstanding the above, if during the Term of the Lease, toxic mold or other hazardous materials are discovered in the Premises through scientific testing, and such contaminants do not arise out of any act or omission of Tenant, Tenant shall have the right to terminate this Lease by giving thirty (30) days' notice to Landlord and Tenant shall not be subject to penalty.

21. **Default by Tenant.** If default shall at any time be made by Tenant in the payment of Rent when due to Landlord as herein provided, and if said default shall continue for ten (10) days after written notice thereof shall have been given to Tenant by Landlord, or if default shall be made in any of the other covenants or conditions to be kept, observed and performed by Tenant, and such default shall continue for more than thirty (30) days after receipt by Tenant of notice thereof in writing from Landlord specifying in detail the nature of such default and fail to commence and thereafter diligently prosecute a cure to such default, Landlord may declare the Term of this Lease ended and terminated and collect any unpaid rentals by giving Tenant written notice of such intention, and if possession of the Premises is not surrendered, Landlord may reenter said Premises and take possession thereof. Notwithstanding the foregoing, if the nature of the default is such that it cannot be cured within said thirty (30) day period, Tenant shall not be in default hereunder if Tenant shall commence to cure such breach and thereafter rectify and cure such breach with due diligence. Landlord shall have, in addition to the remedy above provided, any other right or remedy available to Landlord on account of any Tenant default, either in law or equity.
22. **Default by Landlord.** If Landlord shall default in fulfilling any of the covenants or provisions of this Lease on its part to be performed and shall fail to remedy the default within thirty (30) days after Landlord shall have received written notice from Tenant of such default, then, in addition to all rights, powers and remedies permitted to Tenant by law and in equity, Tenant shall have, without limiting the generality of the foregoing, the right to: (a) remedy Landlord's default and charge Landlord for the cost of remedying the default by withholding Rent or otherwise; (b) allow the default to continue and reduce the payment of Rent by reason of the default; (c) terminate this Lease upon written notice to the Landlord effective either on the date of such notice or on any later date specified in such notice. Tenant's obligation under this Lease including, without limitation, Tenant's obligation to pay Rent or make any other payments to Landlord under this Lease shall cease, and this Lease shall terminate on the date specified in the notice. Notwithstanding anything to the contrary herein, if a Landlord default occurs consisting or amounting to dispossession of the Tenant, Tenant may immediately elect to exercise its remedies hereunder irrespective of any Landlord cure period hereunder. All of Tenant's rights, as stated in this Lease, are cumulative and additional to any other remedy that the Tenant might have at law or in equity.
23. **Quiet Possession.** Landlord covenants and warrants that upon performance by Tenant of its obligations hereunder, Landlord will keep and maintain Tenant in exclusive, quiet, peaceable and undisturbed and uninterrupted possession of the Premises during the Term of this Lease.
24. **Termination Option.** Once tenant has satisfied thirty-eight (38) months of the Initial Term, Tenant may terminate this Lease at any time, with or without cause, by providing the Landlord

with written notice at least thirty (30) days prior to said termination and a payment in the amount of \$4,000.00.

25. **Holding Over.** If Tenant should remain in possession of the Premises after the expiration of the Term, without the execution by Landlord and Tenant of a new Lease or an extension of this Lease, then Tenant shall be deemed to be holding over the Premises and shall remain subject to all of the covenants and obligations of the Lease, and Tenant shall continue to pay the then-current monthly rate, so long as Tenant does not hold over for a period of longer than 30 days, after which Tenant shall pay a monthly rental rate of 125% of the then-current rental rate. The inclusion of the preceding sentence shall not be construed as Landlord's consent for Tenant to hold over. To the extent that Tenant holds over for a period of time that is shorter than one month, the rent shall be prorated according to the number of days held over.
26. **Condemnation.** If any legally, constituted authority condemns the (i) Building or such part thereof which shall make the Premises unsuitable for leasing, (ii) any part of the parking areas serving the Building such that the parking ratio provided for in Section 18 is not available to Tenant or (iii) any part of the common areas, this Lease shall cease when the public authority takes possession, and Landlord and Tenant shall account for rental as of that date. Such termination shall be without prejudice to the rights of either party to recover compensation from the condemning authority for any loss or damage caused by the condemnation. Neither party shall have any rights in or to any award made to the other by the condemning authority.
27. **Subordination.** Tenant accepts this Lease subject and subordinate to any mortgage, deed of trust or other lien presently existing or hereafter arising upon the Premises, or upon the Building and to any renewals, refinancing and extensions thereof, but Tenant agrees that any such mortgagee shall have the right at any time to subordinate such mortgage, deed of trust or other lien to this Lease on such terms and subject to such conditions as such mortgagee may deem appropriate in its discretion. Landlord is hereby irrevocably vested with full power and authority to subordinate this Lease to any mortgage, deed of trust or other lien now existing or hereafter placed upon the Premises or the Building, and Tenant agrees upon demand to execute such further instruments subordinating this Lease or attorning to the holder of any such liens as Landlord may request. Said subordination shall be upon the express condition that this Lease shall be recognized by the mortgagees and that the rights of Tenant shall remain in full force and effect and undisturbed during the Initial Term of this Lease and all extensions hereof and Landlord shall use reasonable efforts to obtain appropriate non-disturbance agreements in favor of Tenant from all existing and any future holders of mortgages on the Premises. Tenant agrees that it will from time to time upon request by Landlord execute and deliver to such persons as Landlord shall request a statement in recordable form certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the same is in full force and effect as so modified), stating the dates to which rent and other charges payable under this Lease have been paid, stating that Landlord is not in default hereunder (or if Tenant alleges a default stating the nature of such alleged default) and further stating such other matters as Landlord shall reasonably require.
28. **Notice.** Any notice required or permitted under this Lease shall be deemed sufficiently given or served if sent by United States certified mail, return receipt requested, addressed as follows:

If to Landlord to:

Roger Ball
1894 HWY 25E
Tazewell, TN 37879
Attn: Roger Ball
Ph: (423) 626-9393
Email rball@ballrealty.com

If to Tenant to:

Tennessee Nursing Services of Morristown, Inc.
9510 Ormsby Station Rd
Suite 300
Louisville, KY 40223
Attn: Administrative Services Coordinator
Ph: (502) 891-1000

With Copy to:

Swearingen Realty Group, LLC
5950 Berkshire Lane, Suite 500
Dallas, Texas 75225
Attn: Lease Administration

Landlord and Tenant shall each have the right from time to time to change the place notice is to be given under this paragraph by written notice thereof to the other party.

29. **Brokers.** Landlord and Tenant represent and warrant to the other that they have dealt only with Swearingen Realty Group, LLC ("Broker") in connection with this Lease and that, insofar as they know, no other broker negotiated or is entitled to any commission in connection with this Lease. Landlord will pay any commission owed to Broker and will indemnify and defend Tenant from and against all claims (and costs of defending against and investigating such claims) of any broker or similar parties, including Broker, claiming under Landlord in connection with this Lease.
30. **Waiver.** No waiver of any default of Landlord or Tenant hereunder shall be implied from any omission to take any action on account of such default if such default persists or is repeated, and no express waiver shall affect any default other than the default specified in the express waiver and that only for the time and to the extent therein stated. One or more waivers by Landlord or Tenant shall not be construed as a waiver of a subsequent breach of the same covenant, term or condition.
31. **Headings.** The headings used in this Lease are for convenience of the parties only and shall not be considered in interpreting the meaning of any provision of this Lease.
32. **Successors.** The provisions of this Lease shall inure to the benefit of and be binding upon Landlord and Tenant and their respective legal representatives, successors and assigns.

33. Compliance with Law. Landlord shall comply with all laws, orders, ordinances and other public requirements now or hereafter pertaining to Landlord's ownership of the Building.
34. Final Agreement. This Lease terminates and supersedes all prior understandings or agreements on the subject matter hereof. This Lease may be modified only by the written consent of the parties hereto.
35. Governing Law. This Lease shall be governed, construed and interpreted by, through and under the Laws of the State of Tennessee.
36. Miscellaneous Provisions.
- a. The fact that this Lease may have been prepared by either Landlord or Tenant, or by the attorneys for either party, shall not justify the resolving of whatever, if any, doubt there may be against said party.
 - b. If any provision of this Lease should be or become prohibited under any applicable law(s), then the remaining provisions of the Lease shall remain in full force, unless an essential purpose of this Lease would be defeated by the loss of any such prohibited provision.
 - c. In the event that it shall become necessary for Landlord or Tenant to employ the services of an attorney to enforce any of its rights under this Lease or to collect any sums due to it under this Lease or to remedy the breach of any covenant of this Lease on the part of the other party the prevailing party in any such action shall be entitled to recover all reasonable attorney's fees.
37. Confidentiality of Medical Records. Inasmuch as the nature and practice of Tenant's business involves the use and maintenance of private and confidential medical records and other individually-identifiable health information, Landlord hereby covenants, warrants, and agrees that neither Landlord, its employees, agents, contractors, invited guests, or assigns shall view, inspect, observe, read, examine, document, copy, disseminate, distribute, or otherwise disclose confidential medical records and/or other individually-identifiable health care information that may be located, stored, or otherwise maintained at or on the Premises, regardless of the nature, source, or storage medium of said confidential information. Landlord shall notify Tenant of any entry into the Premises made by Landlord and/or its employees, agents, contractors, invited guests, or assigns. In the event that Landlord and/or its employees, agents, contractors, invited guests, or assigns enters the Premises, Landlord covenants, warrants, and agrees that said party shall at all times maintain the confidentiality of any and all medical records and/or other individually-identifiable health care information to which said party may have access, and Landlord shall ensure that any and all persons entering the Premises at its request or acquiescence, by its authority, or on its behalf shall strictly abide by the terms of this section. Landlord further agrees to immediately notify Tenant of any violation of this section or other compromise of private and confidential medical records and/or other individually-identifiable health information belonging to Tenant of which Landlord becomes aware. Landlord also agrees to execute any additional confidentiality agreement(s) subsequently requested by Tenant as required by the federal government under the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).

38. No Remuneration for Referrals. Nothing in this agreement, whether written or oral, nor any consideration in connection herewith, contemplates or requires the referral of any patient to Tenant. This agreement is not intended to influence the judgment of any person in choosing the provider appropriate for the proper treatment and care of the patient. No party to this agreement shall receive any compensation or remuneration for arranging for the furnishing of any item or service for which payment may be made in whole or in part by Medicare or Medicaid, or which otherwise may be deemed to violate any federal or state law.
39. Construction of Premises. Landlord agrees that at its own cost and expense, it will make alterations and improvements to the Premises to prepare the same for Tenant's occupancy in accordance with Exhibit "B". In the event that Landlord is prevented from completing the Work (as defined in Exhibit "B") on or before the Target Date due to strikes, lockouts, labor controversies, accidents or other causes beyond the reasonable control of Landlord ("Force Majeure"), Landlord shall not be liable to Tenant for damages by reason thereof, nor shall Tenant be relieved from any obligation under this Lease, but the Rent as provided herein shall be abated on a per diem basis, and the Commencement Date shall not occur until the said alterations and improvements are completed. Notwithstanding anything herein to the contrary, if the Work is not fully completed by the date that is sixty (60) days after the Target Date (subject to Force Majeure), then Tenant, at its option, may terminate this Lease by written notice thirty (30) days after said sixty (60) day period to Landlord without any further obligation on its part and Landlord shall be responsible for reimbursing Tenant for any costs expended in connection with this Lease and/or the Premises.
40. Force Majeure. Neither Landlord nor Tenant shall incur liability to the other with respect to, and shall not be responsible for any failure to perform, any of their respective obligations hereunder if such failure is caused by any reason beyond the control of either party, and shall also include, but not be limited to, reason of strike, other labor trouble, governmental rule, regulations, ordinance, statute or interpretation, or by fire, earthquake, civil commotion, or failure or disruption of utility services. The amount of time for either party to perform any of its respective obligations shall be extended by the amount of time the responsible party is delayed in performing such obligation by reason of any such occurrences.
41. Exhibits. All exhibits referred to herein shall be considered a part hereof for all purposes with the same force and effect as if copied at full length herein. The exhibits attached hereto are listed as follows:
- Exhibit A - Floor Plan
Exhibit B - Work Letter
Exhibit B-1 - Base Building Definition

[Signature Page to Follow]

IN WITNESS WHEREOF, the parties have executed this Lease as of the day and year first above written.

Landlord

Roger A. Ball & Carroll Rose, dba: Rockwood Shopping Center

By: 

Name: Roger A. Ball
Title: Managing Partner

Tenant

Tennessee Nursing Services of Morristown, Inc.

By: 

Name: Todd Lyles
Title: Senior Vice President

EXHIBIT "B"

WORK LETTER TO LEASE

1. Acceptance of Premises. Except as set forth in the Lease or this Exhibit, Tenant accepts the Premises in their "AS-IS" condition on the date that this Lease is entered into, except for any pre-existing conditions within the Premises or common areas surrounding the Premises that do not meet current state, federal and local code requirements (including the ADA) which can affect issuing the construction permit and/or inspection processes and final certificate of occupancy or any latent defects to the Building or Premises.

Upon Lease execution, Landlord will prepare the Premises for construction. Additionally, Landlord will be responsible for obtaining any required inspections including asbestos and/or removal at Landlord's sole cost for obtaining a construction permit prior to the start of construction.

2. Construction Contracts. Landlord shall Turnkey the work and enter into an AIA construction contract or similar contract with a general contractor selected by Landlord which shall comply with the provisions of this Exhibit B and provide for, among other things, i) a one-year warranty for all defective Work; ii) a requirement that the general contractor perform the Work in substantial accordance with the Space Plans and the Construction Documents and in a good and workmanlike manner and; iii) a requirement that the general contractor is responsible for daily clean-up work and final clean up (including removal of debris).

Turnkey. Landlord agrees, prior to the Commencement Date, to complete the following work (the "Work") at the Premises at Landlord's Expense per Exhibit A attached herein.

3. Change Orders. Only the Tenants authorized representative may initiate changes in the Work in a written request, no local manager or employee may initiate a change order. Each such change must receive the prior written approval of Landlord within three (3) days from submission, such approval not to be unreasonably withheld, conditioned or delayed. If Tenants authorized representative requests any changes to the Work described in the Space Plans or the Construction Documents, then such increased costs and any additional design costs incurred in connection therewith as the result of any such change shall be added to the Total Construction Costs.
4. Walk-Through/Punch List. When Landlord considers the Work in the Premises to be Substantially Completed, Landlord will notify Tenants Representative to schedule a walk through. Landlord's Representative and a representative of Tenant shall conduct a walk-through of the Premises within a reasonable time frame and identify any necessary touch-up work, repairs and minor completion items that are necessary for final completion of the Work. Neither Landlord's Representative nor Tenant's Representative shall unreasonably with hold, condition or delay his or her agreement on punch list items. Landlord shall use reasonable efforts to cause the general contractor performing the Work to complete all punch list items within 30 days after agreement thereon.

Finished Floor:

If the Building/Premises floor/slab is not completely finished, the Landlord will be responsible for said completions according to Tenant's final plan at Landlord's sole cost.

Board for Licensing Health Care Facilities



State of

Tennessee

License No. 0000000362

DEPARTMENT OF HEALTH

This is to certify that a license is hereby granted by the State Department of Health to

to conduct and maintain a

MISSISSIPPI NURSING SERVICE OF MORRISTOWN, INC.

As per

SUNCREST HOSPICE

Located at

903 MAIN STREET, FAZEWELL

County of

OLA BORNE

Tennessee

This license shall expire

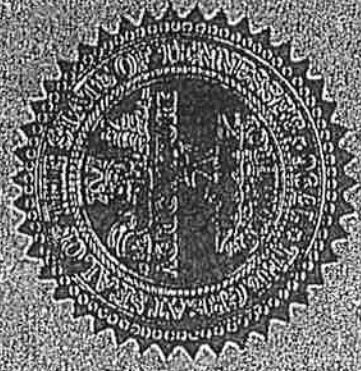
NOVEMBER 03

2017

and is subject

to the provisions of Chapter 15, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State the 15th day of SEPTEMBER, 2016



By *Director, Division of Health Care Facilities*

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

DAH



Almost Family, Inc.

9510 Ormsby Station Road, Suite 300
Louisville, KY 40223
502.891.1000 Fax: 502.891.8067

December 27, 2016

LaRinda Pratt
Bureau of Health Licensure and Regulation
Division of Health Care Facilities
665 Mainstream Drive
2nd Floor
Nashville, TN 37243

RE: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Hospice
License # 362
Change of Address

Dear LaRinda:

Effective January 3, 2017, Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Hospice, currently located at 409 Cawood Road, Tazewell, TN 37879, will be moving. The new address will be as follows:

903 Main Street
New Tazewell, TN 37825

I have enclosed a copy of the lease. The phone and fax numbers will remain the same. If you need further information, please contact me at LauraJoBland@almostfamily.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Laura Jo Bland', written in a cursive, flowing style.

Laura Jo Bland
Compliance Coordinator

Enclosure

waller

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

MAR 29 '17 PM 9:54

11

March 29, 2017

VIA HAND DELIVERY

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Tennessee Nursing Services of Morristown

Dear Melanie:

Prior to March 1, 2016, the applicant used the Tazewell office as its parent office and had branch offices in Jefferson City and Kingsport. The applicant sent a letter to the Department of Health, Board for Licensing Health Care Facilities on January 29, 2016 notifying the Board that it was relocating the principal office for its home health agency from Tazewell to Jefferson City, TN as well as consolidating its operations in Jefferson City, which it had previously operated as a branch office of the agency, effective March 1, 2016.

On June 21, the applicant received a letter acknowledging the address change of its parent office from Tazewell to Jefferson City, effective March 1, 2016, from the Board for Licensing Health Care Facilities. It also received a new license with the address change. On February 2, the applicant sent a notice to Palmetto GBA, its fiscal intermediary for Medicare, along with the appropriate CMS855A forms to effect the change described above. A letter dated March 21, 2016 was sent to the applicant from Palmetto GBA on behalf of CMS, which stated it had completed the updates requested effective March 1, 2016. The applicant was totally unaware that such a change required prior approval from the Tennessee Health Services and Development Agency (HSDA).

The applicant received a letter from the Board for Licensing Health Care Facilities, dated September 27, 2016, which rescinded the change of address. The letter was sent from the Director of Licensure for the Board for Licensing Health Care Facilities notifying the applicant that it had not received prior approval from the HSDA as required. The applicant filed its CON application in December to take steps to comply with this directive.

Sometime in October or November, after receiving the letter from the Licensing Board, the applicant reverted to using the Tazewell office as the office for its parent agency. The property was still being leased because the property was being used by a sister hospice agency as an office.

Then, effective January 3, 2017, the hospice and the HHA relocated to another location within Claiborne County. The new location is 903 Main Street, New Tazewell, TN 37825.

waller

Ms. Melanie Hill
March 29, 2017
Page 2

MAR 29 '17 09:54

Upon approval for relocation, the applicant anticipates moving to Jefferson City, and the hospice may remain at the New Tazewell location. The Jefferson City location is currently being used as a branch office for the HHA.

If you have any questions or need additional information, please do not hesitate to call me.

Sincerely,



Kim Harvey Looney

KHL:lag

Kim Looney

From: Todd Lyles <ToddLyles@almostfamily.com>
Sent: Wednesday, April 12, 2017 4:09 PM
To: Margaret Royar
Cc: Kim Looney
Subject: FW: Office Relocation Tazewell 132-38

See email announcing the move of the Tazewell Hospice office.
TL

Todd Lyles

Sr. Vice President Administration
(502) 891-1044; (502) 891-8067 fx

From: Loretta Scott-Frempong
Sent: Wednesday, January 04, 2017 5:34 PM
To: Corporate Office
Subject: Office Relocation Tazewell 132-38

All:

Effective 1/3/2017 the SunCrest Hospice 132-38 office in Tazewell, TN has relocated. Please see the new address listed below and update your records accordingly.

New Address:

Tazewell Suncrest Hospice
903 Main Street
New Tazewell, TN 37825

Old Address:

Tazewell Suncrest Hospice
409 Cawood Road
Tazewell, TN 37879

Thanks,

Loretta Scott-Frempong,

Administrative Services Coordinator

9510 Ormsby Station Rd, Suite 300 | Louisville, KY 40223

☎ Office: 502-891-1035 | 📠 Fax: 502-891-8067 | ✉ E-Mail: Lorettascott-frempong@almostfamily.com



CONFIDENTIALITY NOTICE: "This is intended for the use of the individual or entity to which it is addressed, and may contain confidential information. If the reader of this message is not the intended recipient or an employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this message is strictly prohibited. If you have



Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

MAR 29 '17 AM 9:54

March 29, 2017

VIA HAND DELIVERY

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Tennessee Nursing Services of Morristown

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Ms. Melanie Hill
March 29, 2017
Page 2

MAR 29 '17 AM 9:54

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Sincerely,



Kim Harvey Looney

KHL:lag

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
APRIL 26, 2017
APPLICATION SUMMARY**

NAME OF PROJECT: Tennessee Nursing Services of Morristown, Inc.
D/b/a SunCrest Home Health

PROJECT NUMBER: CN1612-042

ADDRESS: 657 Broadway, Suite C
Jefferson City (Jefferson County), Tennessee 37760

LEGAL OWNER: SunCrest Home Health of Claiborne County, Inc.
657 Broadway, Suite C
Jefferson City, TN 37760-4949

OPERATING ENTITY: N/A

CONTACT PERSON: Kim Looney, Attorney
Waller Lansden Dortch & Davis LLP
511 Union Street, Suite 2700
Nashville (Davidson County), Tennessee 37219
(615) 850-8722

DATE FILED: December 15, 2016

PROJECT COST: \$306,432

FINANCING: Cash Reserves

PURPOSE FOR FILING: Relocation of the parent office of a home health agency from Claiborne County to Jefferson County

DESCRIPTION:

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health requested and received approval to place this application on the ***Consent Calendar*** for the relocation of its parent office from Tazewell (Claiborne County) TN to Jefferson City (Jefferson County), TN. There will be no change in the applicant's licensed service area. This application was removed from Consent Calendar consideration on April 10, 2017 due to the applicant's failure to disclose pertinent information regarding a second relocation of the principal (parent)

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

PAGE 1

agency during the application review process. See Ms. Hill's cover memo for more details.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. For relocation or replacement of an existing licensed health care institution:
 - a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

The proposed relocation will place the principal office in a geographic location that is more centrally located within the service area and is located closer to more of the patients it serves. The move of the principal location of the home health agency reduces administrative costs by \$87,000 annually. Renovation of the existing principal office is not applicable in this situation.

It appears that the application meets this criterion.

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The applicant expects 9.8% growth in patient visits from 29,323 patient visits in 2014 to 31,621 projected patient visits in Year 2 (2018).

It appears that the application meets this criterion.

Staff Summary

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

Application Synopsis

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health is an established home health agency licensed in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan, and Union Counties. The applicant is seeking approval to relocate its parent office from Claiborne County to its existing branch office located at 657 Broadway, Suite C, Jefferson City (Jefferson County), TN.

If approved, the Claiborne County location will no longer be used for home health services. There will be no change to the applicant's licensed 11 county service area.

An overview of the project is provided on pages 2-4 of the original application.

The applicant projects the initiation of service on May 17, 2017.

Facility Information

- The proposed principal home health office consists of a total of 4,123 SF and includes a reception area, offices areas (9), a conference room, supply room, kitchen area, intake area, storage areas and separate home health and private duty staff areas.
- The proposed location borders U.S. Highway 11E.

Ownership

- Tennessee Nursing Services of Morristown, Inc. formed December 4, 1978 is an active registered business with the Tennessee Secretary of State.
- Tennessee Nursing Services of Morristown, Inc. is owned by SunCrest Home Health of Claiborne County, Inc.
- An organizational chart is included in Attachment A-4A.

Project History

- As previously noted, this application seeks approval to relocate the existing principal (parent) office from Claiborne County to an existing branch office in Jefferson City in Jefferson County. The Claiborne County home health office will be closed which will result in reduced

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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administrative costs. The applicant notes it proceeded with this plan after receiving approval from the Department of Health without realizing a certificate of need was required. Once the applicant was notified by the department that it was rescinding its approval because it had not received the required CON, it relocated back to the original Tazewell location at 409 Cawood Road until the lease expired and then effective January 3, 2017 both it and a sister hospice agency relocated to 903 Main Street, New Tazewell, Tennessee 37825. Please note a home health and hospice are permitted to relocate within the same county without a CON. Please see the executive summary and the March 29, 2017 letter from Kim Looney for a detailed explanation. A timeline follows:

- January 29, 2016-Notified TDH Board for Licensing Health Care Facilities that effective March 1, 2016 it would relocate the principal office from Claiborne County to Jefferson County and consolidate its operations, deleting the Jefferson City branch designation. Indicated Medicare would be notified.
- February 2, 2016-Forms sent to Palmetto GBA (Medicare fiscal intermediary) to submit the change of the principal home health location.
- March 21, 2016-CMS acknowledged principal office relocation with an effective date of March 1, 2016.
- June 21, 2016- TDH Board for Licensing Health Care Facilities acknowledged relocation effective March 1, 2016 and issued new license.
- September 27, 2016- Director of TDH Board for Licensing Health Care Facilities notified applicant by letter of this date it had not received prior approval (CON) to relocate agency.
- October/November 2016-reverted to using Tazewell (Claiborne County) office
- December 15, 2016-CON application filed.
- January 3, 2017-relocated to New Tazewell (Claiborne County). The Jefferson City (Jefferson County) location functions as a branch office and the New Tazewell (Claiborne County) location functions as the principal office pending the outcome of the CON application process.
- January 30, 2017-Application deemed complete.

NEED

Project Need

The applicant cites the following reasons for relocation of the principal office:

- The move of the principal location of the home health agency reduces administrative costs by \$87,000 annually.

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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- The relocation will place the principal office in a geographic location that is more centrally located within the service area and is located closer to more of the patients it serves.

Service Area Demographics

- The total population of the existing 11 county service area is estimated at 574,251 residents in calendar year (CY) 2016 increasing by approximately 2.0% to 585,656 residents in (PY) 2020.
- The overall statewide population is projected to grow by 4.3% from 2016 to 2020.
- The 65 and older population will increase from 119,000 in 2016 by approximately 18.4% to 134,678 in 2020. The statewide 65 and older population is projected to increase by 13.1% between 2016 and 2020.
- The latest 2016 percentage of the service area population enrolled in the TennCare program is approximately 25.0%, as compared to the statewide enrollment proportion of 22.9%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Service Area Historical Utilization

The trend of home health patients served in the existing 11-county service area is presented in the table below:

Service Area Home Health Utilization Trends

	2013 HH Patients	2014 HH Patients	2015 HH Patients	2013-2015 % Changed
11-County Service Area	21,568	20,223	21,222	-1.6%

Source: 2013-2015 Home Health Joint Annual Report and DOH Licensure Applicable Listings

- The preceding chart demonstrates there has been a 1.6% decrease in home health patients residing in the 11-County service area between 2013 and 2015.

Applicant Historical and Projected Utilization

	2014	2015	2016 Projected	2017 Projected	2018 Projected	'14-'18 % Change
Visits	29,323	28,316	29,806	30,700	31,621	7.8%

Source: CN1612-042

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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The chart above indicates the following:

- The applicant expects 7.8% growth in patient visits between 2014 and 2018.

ECONOMIC FEASIBILITY

Project Cost

The estimated total project cost is \$306,432.

Major cost(s) are:

- Facility Lease-\$246,432 or 80.4% of total cost.

For details of the Project Cost Chart, see page R-23 of the original application and Supplemental #1.

Financing

A January 13, 2017 letter from Tennessee Nursing Services of Morristown, Inc.'s Senior Vice President and Secretary, confirms Tennessee Nursing Services of Morristown, Inc.'s has agreed to fund the project from the cash reserves of the company. The letter is co-signed by the Chairman/CEO of Almost Family, Inc. who notes the financial obligations for the certificate of need application will be guaranteed by the corporate parent. Tennessee Nursing Services of Morristown, Inc. is a fourth tier wholly owned subsidiary of Almost Family, Inc.

Almost Family Inc.'s audited financial statements for the period ending January 1, 2016 indicates \$7,522,000 in cash and cash equivalents, total current assets of \$464,769,000, total current liabilities of \$190,869,000, and a current ratio of 2.43:1.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Historical Data Chart

- According to the Historical Data Chart, the applicant reported the following gross operating revenue: \$4,263,273 in 2014, \$4,745,213 in 2015; and \$5,159,118 for 2016.
- According to the Historical Data Chart the applicant experienced positive net operating income for two of the three most recent years reported: (\$71,403) for 2014; \$264,900 for 2015; and \$202,660 for 2016.
- The net operating margin was favorable in two of the last three years at approximately (2.0%), 6.8%, and 4.6% for the Years 2014, 2015, and 2016, respectively.

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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Projected Data Chart

The Projected Data Chart for the applicant reflects \$5,313,891 in gross operating revenue on 30,700 patient visits during the first year of operation and \$5,473,308 on 31,621 patient visits in Year Two. The Projected Data Chart reflects the following:

- Net balance (Net Income - (Annual Principal Debt Repayment + Annual Capital Expenditure) for the applicant will equal \$353,108 in Year One (2017) increasing to \$379,809 in Year Two (2018).

Charges

In Year One of the proposed project:

- The average gross charge/visit is projected to be \$173.09
- The average deduction from revenue is \$27.34.
- The average net charge is \$145.75

Medicare/TennCare Payor Mix

- TennCare-In 2017 the applicant projects \$124,876 in TennCare/Medicaid or 2.35% of projected gross revenue.
- Medicare-In 2017 the applicant projects \$4,973,271 in Medicare or 93.6% of total gross revenue.
- The applicant is contracted with all TennCare Managed Care Organizations except for United Healthcare Community Plan.

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- Tennessee Nursing Services of Morristown, Inc. is licensed by the Tennessee Department of Health. A letter dated November 16, 2015 from the Tennessee Department of Health states that no deficiencies were cited as a result of the licensure survey on November 3-5, 2015.

Certification

- The applicant is certified by Medicare and Medicaid/TennCare.

Accreditation

- Tennessee Nursing Services of Morristown, Inc. is accredited by The Joint Commission.

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

- The applicant is an existing home health agency with established relationships with hospitals, nursing homes, and managed care organizations. A complete listing is located in Supplemental #1.

Impact on Existing Providers

- Since the project consists only of a principal office relocation and no change in the service area counties, the proposed project should have no negative effect on the existing health care system.

Staffing

The applicant's current and proposed staffing is as follows:

Position	Current FTEs	Proposed FTEs
Registered Nurses	4.8	4.8
Licensed Practical Nurses	3.0	3.0
Physical Therapy Services	7.6	7.6
Occupational Therapy	2.6	2.6
Speech/Language Pathology Services	1.0	1.0
Medical Social Services	1.0	1.0
Home Health Aide	3.2	3.2
Total Direct Care Positions	23.2	23.2
Total Non-Patient Care Pos.	16.0	14.0
Contractual Staff	28	28
TOTAL	67.2	65.2

Source: CN1612-042, Page R-33

Corporate documentation, real estate lease, and invoices for office construction are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **two** years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

PAGE 8

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

Pending Applications

AxelaCare Health Solutions, LLC, CN1702-008, has a pending application scheduled to be heard at the June 28, 2017 Agency meeting for addition of 34 East Tennessee Counties to an established home care organization limited to the home infusion of immune globulin pharmaceuticals. The principal office will be located at 5100 Poplar Avenue, 27th Floor, Suite 2739, Memphis (Shelby County) Tennessee. The estimated project cost is \$70,000.

Denied Applications

Critical Nurse Staffing, Inc., CN1210-049D, was denied at the January 23, 2013 Agency meeting for the establishment of a home care organization and initiation of home health services limited to patients who qualify for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) or the Federal Black Lung Program residing in Anderson, Campbell, Knox, Loudon, Monroe, Morgan, Roane, and Union Counties. The estimated project cost was **\$155,937**. *Reason for Denial: The applicant did not provide evidence that need existed nor that services are not being adequately provided by other agencies in the service area.*

Outstanding Certificates of Need

Alere Woman's and Children's Health (Hamilton County), CN1512-057A, has a Certificate of Need that will expire May 1, 2018. The project was approved at the March 23, 2016 Agency meeting for the addition of 23 counties, including Anderson, Blount, Campbell, Carter, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Morgan, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington Counties to the existing 13-county service area of Alere Women's and Children's Health, a home health organization licensed by the Tennessee Department of Health whose parent office is located at 651 East 4th Street, Suite 100, Chattanooga (Hamilton County), TN, 37403. The project will not change the parent office of the applicant nor will it change the provision of services exclusively limited to the care of high-risk obstetrical patients with antepartum and postpartum needs. The estimated project cost is **\$80,600**. *Project Status Update: The project is complete. A final Project Report is pending.*

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

CN1612-042

APRIL 26, 2017

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Coram Alternative Site Services, Inc. d/b/a Coram Specialty Infusion Services, CN1406-017A, has a Certificate of Need that expired on November 1, 2016. The project was approved at the September 24, 2014 Agency meeting for the establishment of a home care organization to provide the following specialized home health services related to home infusion: administer home infusion products and related infusion nursing services, by way of example and not limitation, line maintenance, infusion equipment repair and replacement, and dressing changes on central lines and external access ports. The proposed service area includes the following Tennessee counties: Anderson, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Fentress, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, McMinn, Meigs, Monroe, Morgan, Pickett, Polk, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington Counties, from its licensed home infusion pharmacy which will be located at 10932 Murdock Drive, Suite 101A, Knoxville (Knox County), TN 37932. The estimated project cost is **\$95,200.00**. *Project Status Update: The project is complete. A final Project Report is pending.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME 3/2/2017

LETTER OF INTENT



State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

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DEC 9 '16 AM 11:2

LETTER OF INTENT

The Publication of Intent is to be published in the

The Greeneville Sun (Greene); The
Rogersville Review (Hawkins and
Hancock); Kingsport Times News
(Sullivan); Knoxville News Sentinel
(Claiborne, Campbell, Cocke,
Grainger, Hamblen, Jefferson and
Union counties)

which are newspapers

(Name of Newspaper)

of general circulation in

Campbell, Claiborne, Cocke,
Grainger, Greene, Hamblen,
Hancock, Hawkins,
Jefferson, Sullivan and Union
counties,

(County)

Tennessee, on or before

December 10,
(Month/Day)

20 16
(Year)

for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

home health agency

(Name of Applicant)

(Facility Type-Existing)

owned by: SunCrest Home Health of Claiborne County, Inc.

with an ownership type of

corporation

and to be managed by:

itself

intends to file an application for a Certificate of Need

for : relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its

Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately \$100,000.

The anticipated date of filing the application is:

December 15

20 16

The contact person for this project is

Kim H. Looney, Esq.

Attorney

(Contact Name)

(Title)

who may be reached at:

Waller Lansden Dortch & Davis LLP

511 Union Street, Suite 2700

(Company Name)

(Address)

Nashville

TN

37219

615

/

850-8722

(State)

(Zip Code)

(Area Code)

/

(Phone Number)

Kim H. Looney
(Signature)

December 9, 2016

(Date)

Kim.Looney@wallerlaw.com

(Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

HF51 (revised 01/09/2013 – all forms prior to this date are obsolete.)

4823-0582-7133.1

Original Application

-

COPY

-

TN Nursing Services of
Morristown

CN1612-042

March 29, 2017

VIA HAND DELIVERY

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Tennessee Nursing Services of Morristown

Dear Melanie:

Prior to March 1, 2016, the applicant used the Tazewell office as its parent office and had branch offices in Jefferson City and Kingsport. The applicant sent a letter to the Department of Health, Board for Licensing Health Care Facilities on January 29, 2016 notifying the Board that it was relocating the principal office for its home health agency from Tazewell to Jefferson City, TN as well as consolidating its operations in Jefferson City, which it had previously operated as a branch office of the agency, effective March 1, 2016.

On June 21, the applicant received a letter acknowledging the address change of its parent office from Tazewell to Jefferson City, effective March 1, 2016, from the Board for Licensing Health Care Facilities. It also received a new license with the address change. On February 2, the applicant sent a notice to Palmetto GBA, its fiscal intermediary for Medicare, along with the appropriate CMS855A forms to effect the change described above. A letter dated March 21, 2016 was sent to the applicant from Palmetto GBA on behalf of CMS, which stated it had completed the updates requested effective March 1, 2016. The applicant was totally unaware that such a change required prior approval from the Tennessee Health Services and Development Agency (HSDA).

The applicant received a letter from the Board for Licensing Health Care Facilities, dated September 27, 2016, which rescinded the change of address. The letter was sent from the Director of Licensure for the Board for Licensing Health Care Facilities notifying the applicant that it had not received prior approval from the HSDA as required. The applicant filed its CON application in December to take steps to comply with this directive.

Sometime in October or November, after receiving the letter from the Licensing Board, the applicant reverted to using the Tazewell office as the office for its parent agency. The property was still being leased because the property was being used by a sister hospice agency as an office.

Then, effective January 3, 2017, the hospice and the HHA relocated to another location within Claiborne County. The new location is 903 Main Street, New Tazewell, TN 37825.

DEC 15 1 13 PM '16

December 15, 2016

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

Dear Melanie:

Please be advised that the applicant requests that the application be placed on the consent calendar. The applicant would expect no opposition to this project since it is not adding any counties to its service area.

If you have any questions or need any additional information, please do not hesitate to call me.

Sincerely,



Kim Harvey Looney

KHL:lag

January 27, 2017

10:10am

State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
 www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION**SECTION A: APPLICANT PROFILE****1. Name of Facility, Agency, or Institution**

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

Name

657 Broadway, Suite C

Street or Route

Jefferson

County

Jefferson City

City

TN

State

37760-4949

Zip Code

Website address: N/A

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Kim H. Looney, Esq.

Name

Attorney

Title

Waller Lansden Dortch & Davis LLP

Company Name

kim.looney@wallerlaw.com

Email address

511 Union Street, Suite 2700

Street or Route

Nashville

City

TN

State

37219

Zip Code

Attorney

Association with Owner

615-850-8722

Phone Number

615-244-6804

Fax Number

NOTE: Section A is intended to give the applicant an opportunity to describe the project. **Section B** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care.

Please answer all questions on **8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.** All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). **Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.**

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

- 1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: The applicant is an established home health agency licensed in 11 counties in the northeastern portion of Tennessee. It is seeking to move its principal office from Claiborne County (Tazewell) to Jefferson County (Jefferson City), a distance of just over 49 miles. The applicant also has a branch office in Kingsport (Sullivan County). It will continue to serve the same patient population that it currently serves. The ability to relocate the principal office to an existing branch office and close the existing principal cost will result in reduced administrative costs for the applicant. The applicant anticipates saving \$5,000 per month on administrative staffing and \$2,250 per month on rent for a total annual savings of \$87,000. There is no change in reimbursement as a result of this change.

The applicant sent a letter to the Department of Health, Board for Licensing Health Care Facilities on January 29, 2016 notifying the Board that it was relocating the principal office for its home health agency from Tazewell to Johnson City, TN as well as consolidating its operations in Johnson City, which it had previously operated as a branch office of the agency, effective March 1, 2016. It included its lease and the current state license for their review. At that time, the applicant also stated that it would be notifying CMS to delete the Jefferson City branch designation and to relocate the principal office to this location. On June 21, the applicant received a letter acknowledging the address change of its parent office from Tazewell to Jefferson City, effective March 01, 2016, from the Board for Licensing Health Care Facilities. It also received a new license with the address change.

On February 2, the applicant sent a notice to Palmetto GBA, its fiscal intermediary for Medicare, along with the appropriate CMS855A forms to effect the change described above. A letter dated March 21, 2016 was sent to the applicant from Palmetto GBA on behalf of CMS, which stated it had completed the updates requested effective March 1, 2016. The applicant was totally unaware that such a change required prior approval from the Tennessee Health Services and Development Agency (HSDA). It received a new Tennessee state license with the address change and an approval letter from CMS. It implemented and operated the change in location in reliance upon the approval by both the state and CMS. The applicant did not know it needed to file a CON to relocate the principal office until it received a letter from the Board for Licensing Health Care Facilities, which was not sent until several months after the change had been implemented. The letter was sent from the Director of Licensure and Board for Licensing Health Care Facilities notifying the applicant that it had not received prior approval from the HSDA as required. The applicant, by filing this CON application, is taking steps to comply with this directive.

2) Ownership structure;

Response: The applicant, Tennessee Nursing Services of Morristown, Inc. dba SunCrest Home Health, is owned by SunCrest Home Health of Claiborne County, Inc. An organizational chart is included with this application at Attachment A-4A.

3) Service area;

Response: The applicant is licensed in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union Counties.

4) Existing similar service providers;

Response: Not applicable. While there are a number of licensed home health agencies in the service area, this is an existing provider that is not seeking to add any counties, so there is no effect on any other providers.

5) Project cost;

Response: The only costs associated with the project are legal fees and the filing fees, which are expected to be approximately \$60,000.

6) Funding;

Response: The applicant anticipates funding the minimal project costs from cash reserves.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: Not applicable. This applicant is already licensed and operating and realizing a positive cash margin.

8) Staffing.

Response: The applicant anticipates a reduction in administrative staff as a result of this project. There will be no changes to patient care staffing as a result of this proposal.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The applicant is seeking approval to relocate its principal office from Tazewell (Claiborne County) to Jefferson City (Jefferson County). The office in Jefferson County has been operating as a branch office. Unlike most CON applications, there are no standards or guidelines for this type of project. The applicant is seeking to consolidate some of its operations in order to reduce the administrative costs of operation. This project accomplishes that objective through a reduction in administrative staff and a closure of one of its offices, for an annual reduction in costs of approximately \$87,000 per year. In addition, the relocation will place the principal office in a geographic location that is more centrally located within the service area and is located closer to more of the patients it serves. The applicant will continue to provide the same high quality care to the patients in its service area that it is currently providing to them.

2) Economic Feasibility;

Response: The costs associated with the application are only those that are applicable to the application itself and include legal fees and the HSDA filing fee. The applicant will cut its cost of providing the home health services as it is eliminating the need for a lease in Tazewell and will be able to eliminate a minimum of two administrative staffing positions. The applicant anticipates an annual savings of approximately \$87,000.

3) Appropriate Quality Standards; and

Response: The applicant provides high quality services in its 11 county service area as evidenced by the Quality Report from The Joint Commission and the lack of deficiencies in its last licensure survey.

4) Orderly Development to adequate and effective health care.

Response: Not applicable. The requested change does not affect the applicant's current service area or services provided, and it is currently providing effective health care.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: The applicant is requesting that it be put on the consent calendar. Since it is not requesting additional counties, it would not expect opposition for a project that is seeking to relocate its principal office. A letter has been submitted to the Executive Director simultaneously with the filing of this application.

Owner of the Facility, Agency or Institution

A.

SunCrest Home Health of Claiborne County, Inc.

(865)465-4138

Name

Phone Number

657 Broadway, Suite C

Jefferson

Street or Route

County

Jefferson City

TN

37760-4949

City

State

Zip Code

B. Type of Ownership of Control (Check One)

A. Sole Proprietorship

F. Government (State of TN or
Political Subdivision)

B. Partnership

G. Joint Venture

C. Limited Partnership

H. Limited Liability Company

D. Corporation (For Profit)

X

I. Other (Specify)

E. Corporation (Not-for-
Profit)

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at <https://tnbear.tn.gov/ECommerce/FilingSearch.aspx>. **Attachment Section A-4A.**

Response: See copy of certificate of corporate existence included as Attachment A-4A.

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

5. Name of Management/Operating Entity (If Applicable)

Not applicable

Name

Street or Route

County

City

State

Zip Code

Website address:

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. Attachment Section A-5.

6A. Legal Interest in the Site of the Institution (Check One)

- | | | | |
|----------------------------|----------|--------------------|-------|
| A. Ownership | _____ | D. Option to Lease | _____ |
| B. Option to Purchase | _____ | E. Other (Specify) | _____ |
| C. Lease of <u>3</u> Years | <u>X</u> | | |

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements **must include** anticipated purchase price. Lease/Option to Lease Agreements **must include** the actual/anticipated term of the agreement **and** actual/anticipated lease expense. The legal interests described herein **must be valid** on the date of the Agency's consideration of the certificate of need application.

Response: See copy of lease included as Attachment A-6A.

6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site on an 8 1/2" x 11" sheet of white paper, single or double-sided. DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

- 1) Plot Plan **must** include:
 - a. Size of site (***in acres***);
 - b. Location of structure on the site;
 - c. Location of the proposed construction/renovation; and
 - d. Names of streets, roads or highway that cross or border the site.

Response: See plot plan included as Attachment 6B-1.

- 2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 1/2 by 11 sheet of paper or as many as necessary to illustrate the floor plan.

Response: See floor plan included as Attachment 6B-2.

- 3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

Response: Not applicable. This is a home health agency so the patients do not travel to the provider; the provider travels to the patients.

7. Type of Institution (Check as appropriate--more than one response may apply)

- | | |
|--|--|
| A. Hospital (Specify) _____ | H. Nursing Home _____ |
| B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty _____ | I. Outpatient Diagnostic Center _____ |
| C. ASTC, Single Specialty _____ | J. Rehabilitation Facility _____ |
| D. Home Health Agency <u>X</u> | K. Residential Hospice _____ |
| E. Hospice _____ | L. Nonresidential Substitution-Based Treatment Center for Opiate Addiction _____ |
| F. Mental Health Hospital _____ | M. Other (Specify) _____ |
| G. Intellectual Disability Institutional Habilitation Facility ICF/IID _____ | |

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

- | | |
|--|---|
| A. New Institution _____ | F. Change in Bed Complement _____ |
| B. Modifying an ASTC with limitation still required per CON _____ | [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation] |
| C. Addition of MRI Unit _____ | G. Satellite Emergency Dept. _____ |
| D. Pediatric MRI _____ | H. Change of Location <u>X</u> |
| E. Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify) _____ | I. Other (Specify) _____ |

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

X AmeriGroup ___ United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number 44-7548

Medicaid Provider Number 00-44-7548

Certification Type Home Health Agency

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare ___Yes ___No X N/A Medicaid/TennCare ___Yes ___No X N/A

10. **Bed Complement Data** **Response:** Not applicable.

A. Please indicate current and proposed distribution and certification of facility beds.

	<i>Current Licensed</i>	<i>Beds Staffed</i>	<i>Beds Proposed</i>	<i>*Beds Approved</i>	<i>**Beds Exempted</i>	<i>TOTAL Beds at Completion</i>
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL						
<i>*Beds approved but not yet in service</i> <i>**Beds exempted under 10% per 3 year provision</i>						

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lauderdale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedford	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lawrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lewis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bledsoe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lincoln	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loudon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bradley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McMinn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Campbell	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McNairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carroll	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Madison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheatham	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marshall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claiborne	X <input type="checkbox"/>	X <input type="checkbox"/>	<input type="checkbox"/>	Meigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monroe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocke	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Montgomery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crockett	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morgan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cumberland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Davidson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decatur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DeKalb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pickett	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dickson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Putnam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fayette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Roane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Franklin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Robertson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gibson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rutherford	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scott	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grainger	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sequatchie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greene	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sevier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grundy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shelby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamblen	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smith	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamilton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stewart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hancock	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sullivan	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hardeman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sumner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hardin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tipton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hawkins	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trousdale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haywood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unicoi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Henderson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Union	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Henry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Van Buren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hickman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Warren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Houston	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Washington	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humphreys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wayne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jackson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jefferson	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Johnson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Williamson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wilson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

12. **Square Footage and Cost Per Square Footage Chart** Response: Not applicable

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF							
*Total Cost							
**Cost Per Square Foot							
Cost per Square Foot Is Within Which Range <i>(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hstda)</i>					<input type="checkbox"/> Below 1 st Quartile	<input type="checkbox"/> Below 1 st Quartile	<input type="checkbox"/> Below 1 st Quartile
					<input type="checkbox"/> Between 1 st and 2 nd Quartile	<input type="checkbox"/> Between 1 st and 2 nd Quartile	<input type="checkbox"/> Between 1 st and 2 nd Quartile
					<input type="checkbox"/> Between 2 nd and 3 rd Quartile	<input type="checkbox"/> Between 2 nd and 3 rd Quartile	<input type="checkbox"/> Between 2 nd and 3 rd Quartile
					<input type="checkbox"/> Above 3 rd Quartile	<input type="checkbox"/> Above 3 rd Quartile	<input type="checkbox"/> Above 3 rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or

Response: Not applicable.

2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

Response: Not applicable.

- A. Complete the chart below for acquired equipment.

<input type="checkbox"/> Linear Accelerator	Mev _____	Types:	<input type="checkbox"/> SRS <input type="checkbox"/> IMRT <input type="checkbox"/> IGRT <input type="checkbox"/> Other _____
	Total Cost*:		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) _____
	<input type="checkbox"/> New <input type="checkbox"/> Refurbished		<input type="checkbox"/> If not new, how old? (yrs) _____
<input type="checkbox"/> MRI	Tesla: _____	Magnet:	<input type="checkbox"/> Breast <input type="checkbox"/> Extremity <input type="checkbox"/> Open <input type="checkbox"/> Short Bore <input type="checkbox"/> Other _____
	Total Cost*:		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) _____
	<input type="checkbox"/> New <input type="checkbox"/> Refurbished		<input type="checkbox"/> If not new, how old? (yrs) _____
<input type="checkbox"/> PET	<input type="checkbox"/> PET only <input type="checkbox"/> PET/CT <input type="checkbox"/> PET/MRI		<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) _____
	Total Cost*:		<input type="checkbox"/> If not new, how old? (yrs) _____
	<input type="checkbox"/> New <input type="checkbox"/> Refurbished		

* As defined by Agency Rule 0720-9-.01(13)

- B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response: Not applicable.

- C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

Response: Not applicable.

D. Schedule of Operations:

Location	Days of Operation (Sunday through Saturday)	Hours of Operation (example: 8 am – 3 pm)
Fixed Site (Applicant)	_____	_____
Mobile Locations (Applicant)	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)	_____	_____

E. Identify the clinical applications to be provided that apply to the project.

Response: Not applicable.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

Response: Not applicable.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), “no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care.” Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate “Not Applicable (NA).”***

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency’s website at <http://www.tn.gov/hsda/article/hsda-criteria-and-standards>.

HOME HEALTH SERVICES - STANDARDS AND CRITERIA

1. **Determination of Need:** In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. This 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed Service Area.

Response: Not applicable. The applicant is not adding any counties to its service area.

2. The need for home health services should be projected three years from the latest available year of final JAR data.

Response: Not applicable. The applicant is not adding any counties to its service area.

3. The use rate of existing home health agencies in each county of the Service Area will be determined by examining the latest utilization rate as calculated from the JARs of existing home health agencies in the Service Area. Based on the number

of patients served by home health agencies in the Service Area, an estimation will be made as to how many patients could be served in the future.

Response: Not applicable. The applicant is not adding any counties to its service area.

4. **County Need Standard:** The applicant should demonstrate that there is a need for home health services in each county in the proposed Service Area by providing documentation (e.g., letters) where: a) health care providers had difficulty or were unable successfully to refer a patient to a home care organization and/or were dissatisfied with the quality of services provided by existing home care organizations based on Medicare's system Home Health Compare and/or similar data; b) potential patients or providers in the proposed Service Area attempted to find appropriate home health services but were not able to secure such services; c) providers supply an estimate of the potential number of patients that they might refer to the applicant.

Response: Not applicable. The applicant is not adding any counties to its service area.

5. **Current Service Area Utilization:** The applicant should document by county: a) all existing providers of home health services within the proposed Service Area; and b) the number of patients served during the most recent 12-month period for which data are available. To characterize existing providers located within Tennessee, the applicant should use final data provided by the JARs maintained by the Tennessee Department of Health. In each county of the proposed Service Area, the applicant should identify home health agencies that have reported serving 5 or fewer patients for each of the last three years based on final and available JAR data. If an agency in the proposed Service Area who serves few or no patients is opposing the application, that opponent agency should provide evidence as to why it does not serve a larger number of patients.

Response: Not applicable. The applicant is not adding any counties to its service area.

6. **Adequate Staffing:** Using TDH Licensure data, the applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and document that such personnel are available to work in the proposed Service Area. The applicant should state the percentage of qualified personnel directly employed or employed through a third party staffing agency.

Response: Not applicable. The applicant already has the necessary staff to operate the home health agency and it is not adding any counties to its service area.

7. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, referral arrangements with appropriate health care system providers/services (that comply with CMS

patient choice protections) and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. A new provider may submit a proposed community linkage plan.

Response: Not applicable. The applicant is not adding any counties to its service area. The applicant is an existing home health agency with established relationships with area providers.

8. **TennCare Managed Care Organizations (MCOs) and Financial Viability:** Given the time frame required to obtain Medicare certification, an applicant proposing to contract with the Bureau of TennCare's MCOs should provide evidence of financial viability during the time period necessary to receive such certification. Applicants should be aware that MCOs are under no obligation to contract with home care organizations, even if Medicare certification is obtained, and that Private Duty Services are not Medicare certifiable services. Applicants who believe there is a need to serve TennCare patients should contact the TennCare MCOs in the region of the proposed Service Area and inquire whether their panels are open for home health services, as advised in the notice posted on the HSDA website, to determine whether at any given point there is a need for a provider in a particular area of the state; letters from the TennCare MCOs should be provided to document such need. See Note 2 for additional information.

Response: Not applicable. The applicant is already a TennCare provider and is not adding any counties to its service area.

Applicants should also provide information on projected revenue sources, including non-TennCare revenue sources.

Response: Not applicable. The applicant is not adding any counties to its service area. It anticipates that its revenue sources will remain substantially the same. See the table included below in the response to Question 9.

9. **Proposed Charges:** The applicant's proposed charges should be reasonable in comparison with those of other similar agencies in the Service Area or in adjoining service areas. The applicant should list:
- a. The average charge per visit and/or episode of care by service category, if available in the JAR data.
 - b. The average charge per patient based upon the projected number of visits and/or episodes of care and/or hours per patient, if available in the JAR data.

Response: Please see information below from the 2015 JAR:

	Gross Revenue	Patients	Visits	Rev/Pat	Rev/Visit
TennCare	\$81,590	128	474	\$637.42	\$172.13
Medicare	\$981,679	348	11,805	\$2,820.92	\$83.16
Medicare HMO	\$2,272,690	653	15,126	\$3,480.38	\$150.25
Commercial	\$141,231	162	3,454	\$871.80	\$40.89
TOTAL	\$3,477,190	1,291	30,859	\$2,693.41	\$112.68

10. **Access:** In concert with the factors set forth in HSDA Rule 0720-11-.01(1) (which lists those factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area for groups with special medical needs such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. Pediatrics is a special medical needs population, and therefore any provider applying to provide these services should demonstrate documentation of adequately trained staff specific to this population's needs with a plan to provide ongoing best practice education. For purposes of this Standard, an applicant should document need using population, service, special needs, and/or disease incidence rates. If granted, the Certificate of Need should be restricted on condition, and thus in its licensure, to serving the special group or groups identified in the application. The restricting language should be as follows: **CONDITION:** Home health agency services are limited to (identified specialty service group); the expansion of service beyond (identified specialty service group) will require the filing of a new Certificate of Need application. Please see Note 3 regarding federal law prohibitions on discrimination in the provision of health care services.

Response: Not applicable.

11. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting (including data on patient re-admission to hospitals), quality improvement, and an outcome and process monitoring system (including continuum of care and transitions of care from acute care facilities). If applicable, the applicant should provide documentation that it is, or that it intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS.

Response: The applicant currently participates in The Joint Commission's Quality Check Program. A copy of the Quality Report is included as Attachment B, Criteria - Need 11.

12. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services

and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response: The applicant plans to provide the Department of Health and/or the HSDA with all reasonably requested information and data related to the operation of the home health agency.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The relocation of the principal office for the applicant is consistent with its long range plans to cut costs where possible in that it allows the applicant to reduce its operating costs for this agency by having two offices instead of 3 in the service area, and reducing the administrative staff, resulting in an average reduction in costs of \$87,000.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment – Section – Need-3.**

Response: The applicant is licensed in Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union Counties.

Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents 2015	% of total procedures
Campbell	13	1.96%
Claiborne	184	27.75%
Cocke	28	4.22%
Grainger	55	8.30%
Greene	5	.75%
Hamblen	70	10.56%
Hancock	6	.90%
Hawkins	51	7.69%
Jefferson	48	7.24%
Sullivan	174	26.24%
Union	29	4.37%
Total	663	100.00%

Service Area Counties	Projected Utilization-County Residents	% of total procedures
County #1		
County #2		
Etc.		
Total		100%

Response: Not applicable. Utilization is not expected to change as a result of this project.

SERVICE AREA



January 27, 2017

10:10am

1. A. 1) Describe the demographics of the population to be served by the proposal.
- 2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: <http://www.tn.gov/health/article/statistics-population>

TennCare Enrollment Data: <http://www.tn.gov/tenncare/topic/enrollment-data>

Census Bureau Fact Finder:

<http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

Demographic Variable/ Geographic Area By County	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population- Current Year	Total Population- Projected Year	Total Population-% Change	*Target Population- Current Year	*Target Population- Project Year	*Target Population- % Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Campbell	41,464	41,787	0.1%	N/A	N/A	N/A	N/A	43.0	32,028	9,224	22.2%	13,469	32.5%
Claiborne	33,800	34,713	2.7%	N/A	N/A	N/A	N/A	41.8	34,899	6,944	20.5%	9,407	27.8%
Cocke	36,976	37,663	1.9%	N/A	N/A	N/A	N/A	44.3	31,187	9,178	24.8%	11,710	31.7%
Grainger	23,890	24,577	2.9%	N/A	N/A	N/A	N/A	43.6	35,391	4,706	19.7%	6,106	25.6%
Greene	72,512	74,656	2.9%	N/A	N/A	N/A	N/A	43.7	35,196	14,060	19.4%	15,787	21.8%
Hamblen	65,332	67,028	2.6%	N/A	N/A	N/A	N/A	39.9	37,617	13,504	20.7%	16,276	24.9%
Hancock	6,951	7,007	0.8%	N/A	N/A	N/A	N/A	44.2	26,898	1,815	26.1%	2,396	34.5%
Hawkins	58,771	59,784	1.7%	N/A	N/A	N/A	N/A	43.4	36,927	10,838	18.4%	14,066	23.9%
Jefferson	55,714	58,372	4.7%	N/A	N/A	N/A	N/A	42.3	42,417	8,786	15.8%	12,721	22.8%
Sullivan	158,938	159,749	0.5%	N/A	N/A	N/A	N/A	44.3	40,346	27,439	17.3%	33,818	21.3%
Union	19,903	20,320	2.1%	N/A	N/A	N/A	N/A	41.0	37,351	4,104	20.6%	5,234	26.3%
Service Area Total	564,251	585,656	3.8%	N/A	N/A	N/A	N/A	42.9	35,478	110,598	19.6%	140,990	25.0%
State of TN Total	6,812,005	7,108,031	4.3%	N/A	N/A	N/A	N/A	38.4	45,219	1,600,000	23.5%	1,489,597	21.9%

* Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.

- B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The applicant currently treats all segments of the population including the elderly, women, racial and ethnic minorities and low income groups.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: Not applicable. The applicant is requesting relocation of its principal office from Claiborne to Jefferson County. This project has no effect on either the applicant's own utilization or the utilization of other area providers.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Not applicable. The applicant is requesting relocation of its principal office from Claiborne to Jefferson County, and the utilization is not relevant to this determination.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

A. All projects should have a project cost of at least \$15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

Response: Please see project costs chart. The only costs are the legal fees and the filing fees.

B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response: Not applicable.

C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response: Not applicable.

D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

Response: Not applicable.

E. For projects that include new construction, modification, and/or renovation—documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

- 1) A general description of the project;
- 2) An estimate of the cost to construct the project;
- 3) A description of the status of the site's suitability for the proposed project; and
- 4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Response: Not applicable.

January 27, 2017**10:10am****PROJECT COST CHART**

A. Construction and equipment acquired by purchase:	
1. Architectural and Engineering Fees	_____
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	<u>\$ 45,000</u>
3. Acquisition of Site	_____
4. Preparation of Site	_____
5. Total Construction Costs	_____
6. Contingency Fund	_____
7. Fixed Equipment (Not included in Construction Contract)	_____
8. Moveable Equipment (List all equipment over \$50,000 as separate attachments)	_____
9. Other (Specify) _____	_____
B. Acquisition by gift, donation, or lease:	
1. Facility (inclusive of building and land) Value of Space	<u>\$246,432</u>
2. Building only	_____
3. Land only	_____
4. Equipment (Specify) _____	_____
5. Other (Specify) _____	_____
C. Financing Costs and Fees:	
1. Interim Financing	_____
2. Underwriting Costs	_____
3. Reserve for One Year's Debt Service	_____
4. Other (Specify) _____	_____
D. Estimated Project Cost (A+B+C)	<u>\$291,432</u>
E. CON Filing Fee	<u>\$15,000</u>
F. Total Estimated Project Cost (D+E)	<u>TOTAL \$306,432</u>

Response: With the exception of legal costs and the filing fee, there are no costs associated with the relocation of the principal office for the applicant. The applicant already operates the office proposed as the principal office as a branch office.

2. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

- ☐ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
- ☐ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
- ☐ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;
- ☐ D. Grants – Notification of intent form for grant application or notice of grant award;
- ☒ E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or
- ☐ F. Other – Identify and document funding from all other sources.

Response: The applicant anticipates covering the minimal costs associated from cash reserves and has included the appropriate documentation from the Senior Vice President and Secretary of the applicant. The funding letter is included as Attachment C, Economic Feasibility 2-E. The 10K for the parent company, Almost Family, Inc., is included as Attachment C, Economic Feasibility-6.

3. Complete Historical Data Charts on the following two pages—**Do not modify the Charts provided or submit Chart substitutions!**

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

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NET INCOME (LOSS)

G. Other Deductions

1. Annual Principal Debt Repayment
2. Annual Capital Expenditure

Total Other Deductions

NET BALANCE

DEPRECIATION

FREE CASH FLOW (Net Balance + Depreciation)

\$(71,403)	\$264,900	\$202,660
\$-0-	\$-0-	\$-0-
\$32,131	\$12,810	\$62,224
<u>\$32,131</u>	<u>\$12,810</u>	<u>\$62,224</u>
<u>\$(103,534)</u>	<u>\$252,090</u>	<u>\$140,436</u>
<u>\$7,477</u>	<u>\$8,732</u>	<u>\$15,644</u>
<u>\$(96,057)</u>	<u>\$260,822</u>	<u>\$156,080</u>

☒ Total Facility
☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES1. Professional Services Contract2. Contract Labor3. Imaging Interpretation Fees4. Administrative/Benefits5. Repairs, Maintenance, Utilities, Cleaning6. Telecom and Copiers7. Other

Total Other Expenses

Year 2014	Year 2015	Year 2016
\$	\$	\$
\$550,750	\$450,851	\$576,213
\$35,373	\$46,446	\$57,851
\$109,039	\$120,671	\$122,498
\$4,927	\$1,121	\$947
<u>\$ 700,089</u>	<u>\$ 619,086</u>	<u>\$ 757,509</u>

4. Complete Projected Data Charts on the following two pages – **Do not modify the Charts provided or submit Chart substitutions!**

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the **Proposal Only** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

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X Total

Facility

□ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 2017	Year 2018
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	30,700	31,621
B. Revenue from Services to Patients		
1. Inpatient Services	\$	\$
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify) Home Health	\$5,313,891	\$5,473,308
Gross Operating Revenue	\$5,313,891	\$5,473,308
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$627,309	\$646,128
2. Provision for Charity Care	302	311
3. Provisions for Bad Debt	211,725	217,637
Total Deductions	\$839,336	\$864,076
NET OPERATING REVENUE	\$4,474,555	\$4,609,232
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	\$2,101,229	\$2,153,760
b. Non-Patient Care	912,136	934,939
2. Physician's Salaries and Wages		
3. Supplies	277,955	286,294
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	70,230	72,337
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses	734,909	756,956
Total Operating Expenses	\$4,096,459	\$4,204,286
E. Earnings Before Interest, Taxes and Depreciation	\$378,096	\$404,946
F. Non-Operating Expenses		
1. Taxes	\$ 4,988	\$ 5,137
2. Depreciation	16,114	16,597
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	\$21,102	\$21,734
NET INCOME (LOSS)	\$356,994	\$383,212

Chart Continues Onto Next Page

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NET INCOME (LOSS)	<u>\$356,994</u>	<u>\$383,212</u>
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	<u>\$ -0-</u>	<u>\$ -0-</u>
2. Annual Capital Expenditure	<u>\$ 20,000</u>	<u>\$ 20,000</u>
Total Other Deductions	<u>\$ 20,000</u>	<u>\$ 20,000</u>
NET BALANCE	<u>\$ 336,994</u>	<u>\$ 363,212</u>
DEPRECIATION	<u>\$ 16,114</u>	<u>\$ 16,597</u>
FREE CASH FLOW (Net Balance + Depreciation)	<u>\$ 353,108</u>	<u>\$ 379,809</u>

- ☐ Total Facility
☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	<u>Year 2017</u>	<u>Year 2018</u>
1. <u>Professional Services Contract</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
2. <u>Contract Labor</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
3. <u>Imaging Interpretation Fees</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
4. <u>Administrative/Benefits</u>	<u>\$566,500</u>	<u>\$583,494</u>
5. <u>Repairs, Maintenance, Utilities, Cleaning</u>	<u>\$41,834</u>	<u>\$43,090</u>
6. <u>Telecom and Copiers</u>	<u>\$126,173</u>	<u>\$129,959</u>
7. <u>Other</u>	<u>402</u>	<u>413</u>
Total Other Expenses	<u>\$ 734,909</u>	<u>\$ 756,956</u>

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5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge (<i>Gross Operating Revenue/Utilization Data</i>)	\$167.58	\$173.09	\$173.09	\$173.09	-0-
Deduction from Revenue (<i>Total Deductions/Utilization Data</i>)	\$29.80	\$25.02	\$27.34	\$27.34	-0-
Average Net Charge (<i>Net Operating Revenue/Utilization Data</i>)	\$137.78	\$148.07	\$145.75	\$145.75	-0-

- B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The applicant does not anticipate any changes to its charges as a result of the implementation of this proposal. The project does not have any incremental revenue and will have no impact on existing patient charges.

- C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Following is information from the 2015 Joint Annual Reports for home health agencies.

HHA	Gross Revenue	Patients	Visits	Rev/Pat	Rev/Visit
Gentiva	\$2,040,611	1,912	12,540	\$1,067.27	\$162.73
Advanced Home Care	\$5,562,153	2,287	38,210	\$2,432.07	\$145.57
Amedisys	\$13,632,114	3,099	100,219	\$4,398.88	\$136.02
Amedisys-Claiborne	\$7,701,253	1,551	56,653	\$4,965.35	\$135.94

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the

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project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: Not applicable. The applicant is an operating home health agency with an established track record. There are no costs or charges that are related to this proposal. A copy of the 10K for Almost Family, Inc. is included as Attachment C, Economic Feasibility.

- B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	-.02	.07	.05	.08	.09

- C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: Not applicable.

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7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: The applicant does not anticipate the payor mix changing significantly.

Applicant's Projected Payor Mix, Year 1

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	\$4,973,270.59	93.59%
TennCare/Medicaid	\$124,876	2.35%
Commercial/Other Managed Care	\$223,863	4.06%
Self-Pay	0	0
Charity Care	0	0
Other (Specify) _____	0	0
Total	\$5,313,891	100%

Note: Because of the home health services it provides and the service area, the amount of self-pay and charity care is negligible compared to the amounts received from payors.

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: The table below shows the current staffing according to the 2015 JAR. The applicant anticipates a reduction in administrative staff as a result of this proposal.

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Position Classification	Existing FTEs 2015	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
A. Direct Patient Care Positions				
<i>Registered Nurses</i>	4.8	4.8	\$55,000	\$56,838
<i>Licensed Practical Nurses</i>	3.0	3.0	\$36,500	\$36,673
<i>Certified Nurse Aides</i>	0	0	\$20,500	\$22,390
<i>Physical Therapy Services</i>	7.6	7.6	\$90,000	\$84,767
<i>Occupational Therapy</i>	2.6	2.6	\$85,000	\$80,370
<i>Speech/Language Pathology Services</i>	1.0	1.0	\$85,000	\$66,645
<i>Medical Social Services</i>	1.0	1.0	\$52,000	\$50,743
<i>Respiratory Therapists</i>	0	0	N/A	N/A
<i>Home Health Aide</i>	3.2	3.2	\$20,500	\$19,033
<i>Homemakers</i>	0	0	N/A	N/A
<i>Nutritionists/ Dieticians</i>	0	0	N/A	N/A
<i>Other Health</i>	0	0	N/A	N/A
<i>Other Non-Health</i>	0	0	N/A	N/A
Total Direct Patient Care Positions	23.2	23.2	\$55,563	N/A
B. Non-Patient Care Positions				
<i>Administrator</i>	1.0	1.0	\$105,000	N/A
<i>Clinical Director/In-Office Clinical Staff</i>	8.0	7.0	\$75,000	N/A
<i>Office Personnel (Clinical)</i>	4.0	3.0	\$60,000	N/A
<i>Financial/Billing Personnel</i>	0	0	N/A	N/A
<i>Other Administrative Personnel (Marketing/ Community Education, etc.)</i>	3.0	3.0	\$65,000	N/A
Total Non-Patient Care Positions	16.0	14.0	N/A	N/A
Total Employees (A+B)	39.2	37.2	\$76,250	N/A
C. Contractual Staff	28.0	28.0	\$25,000	N/A
Total Staff (A+B+C)	67.2	65.2	\$52,271	N/A

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

- A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Response: There are no less costly, more effective, and/or more efficient alternatives to this proposal. This request to move the principal office from Claiborne to Jefferson County results in one less office for the agency and a reduction in staff so that expenses are reduced as a result of this proposal.

- B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: Not applicable. This project does not involve construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

Response: Not applicable. The applicant is an existing home health agency with established relationships.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Response: Not applicable. The relocation of a principal office has no effect on competition and does not result in a duplication of services.

B. Negative Effects

Response: Not applicable. The relocation of a principal office has no effect on competition and does not result in a duplication of services.

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: Not applicable. The applicant is an existing licensed home health agency and, as such, meets the required staffing requirements for licensure.

- B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The applicant is currently licensed and understands the applicable licensing and certification requirements.

- C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Not applicable. The applicant does not participate in any student training.

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Response: The applicant is licensed as a home health agency and has received a license from the Tennessee Department of Health, Board for Licensing Health Care Facilities.

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

Response: HHA

Accreditation (i.e., Joint Commission, CARF, etc.):

Response: The applicant is accredited by The Joint Commission.

- A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: The applicant is in good standing with the licensing agency. Attached please find a copy of the current facility license included as Attachment C-4-A.

- B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: Please see attached copy of the most recent statement of deficiencies/plan of correction. There were no deficiencies.

- C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response: None. The applicant's last survey had no deficiencies.

- 1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: Not applicable.

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

- A. Has any of the following:

- 1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: William B. Yarmuth, CEO, has greater than 5% indirect ownership interest in the applicant through his ownership interest in Almost Family, Inc.

- 2) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: Please see a copy of the organization chart included as Attachment A-4-A. Each subsidiary listed is 100% owned by the corporate entity above. For example, Tennessee Nursing Services of Morristown, Inc. is a wholly owned subsidiary of SunCrest Home Health of Claiborne County, Inc.

- 3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: No physician or other entity not already identified has an ownership interest of greater than 5%.

B. Been subjected to any of the following:

- 1) Final Order or Judgment in a state licensure action;

Response: No.

- 2) Criminal fines in cases involving a Federal or State health care offense;

Response: No.

- 3) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: No.

- 4) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: No.

- 5) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: No.

- 6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: No.

- 7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: No.

- 8) Is presently subject to a corporate integrity agreement.

Response: No.

6. Outstanding Projects:

- A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

<u>Outstanding Projects</u>					
<u>CON Number</u>	<u>Project Name</u>	<u>Date Approved</u>	<u>*Annual Progress Report(s)</u>		<u>Expiration Date</u>
			<u>Due Date</u>	<u>Date Filed</u>	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response: Not applicable.

- B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: Not applicable.

7. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

- A. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

Response: Not applicable.

- B. If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?

Response: Not applicable.

- C. If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission?

Response: Not applicable.

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The applicant shall report annually such quality information as is requested and appropriate.

STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at <http://www.tn.gov/health/topic/health-planning>). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Response: The applicant is a licensed home health agency which is always striving to improve the health and health outcomes of the patients it serves.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response: The residents of the 11 counties in which the applicant is licensed have access to these necessary health care services and thus the ability to strive to achieve optimal health.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response: The applicant is an existing provider of home health services and is seeking to increase economic efficiencies by relocating its principal office and closing the current principal office.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: The applicant is accredited by The Joint Commission which monitors quality. In addition, it had no deficiencies on its latest survey the Tennessee Department of Health, Board for Licensing Health Care Facilities.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The applicant currently has sufficient staff to meet the needs of its patients and seeks to hire only the most highly qualified workers.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Please see proof of publication from the Knoxville News Sentinel (Claiborne, Campbell, Cocke, Grainger, Hamblen, Jefferson and Union Counties); The Greeneville Sun (Greene County); The Rogersville Review (Hawkins and Hancock Counties); and Kingsport Times News (Sullivan County).

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.

January 27, 2017

PROJECT COMPLETION FORECAST CHART

10:10am

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

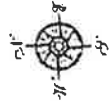
<u>Phase</u>	<u>Days Required</u>	<u>Anticipated Date</u> [Month/Year]
1. Initial HSDA decision date		4/17
2. Architectural and engineering contract signed	N/A	N/A
3. Construction documents approved by the Tennessee Department of Health	N/A	N/A
4. Construction contract signed	N/A	N/A
5. Building permit secured	N/A	N/A
6. Site preparation completed	N/A	N/A
7. Building construction commenced	N/A	N/A
8. Construction 40% complete	N/A	N/A
9. Construction 80% complete	N/A	N/A
10. Construction 100% complete (approved for occupancy)	N/A	N/A
11. *Issuance of License	30-45 Days	5/17 - 6/17
12. *Issuance of Service	30-45 days	5/17 - 6/17
13. Final Architectural Certification of Payment	N/A	N/A
14. Final Project Report Form submitted (Form HR0055)	30 days	7/17

*For projects that **DO NOT** involve construction or renovation, complete Items 11 & 12 only.

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

Attachment Section A, Project Details-Item 4-B.1

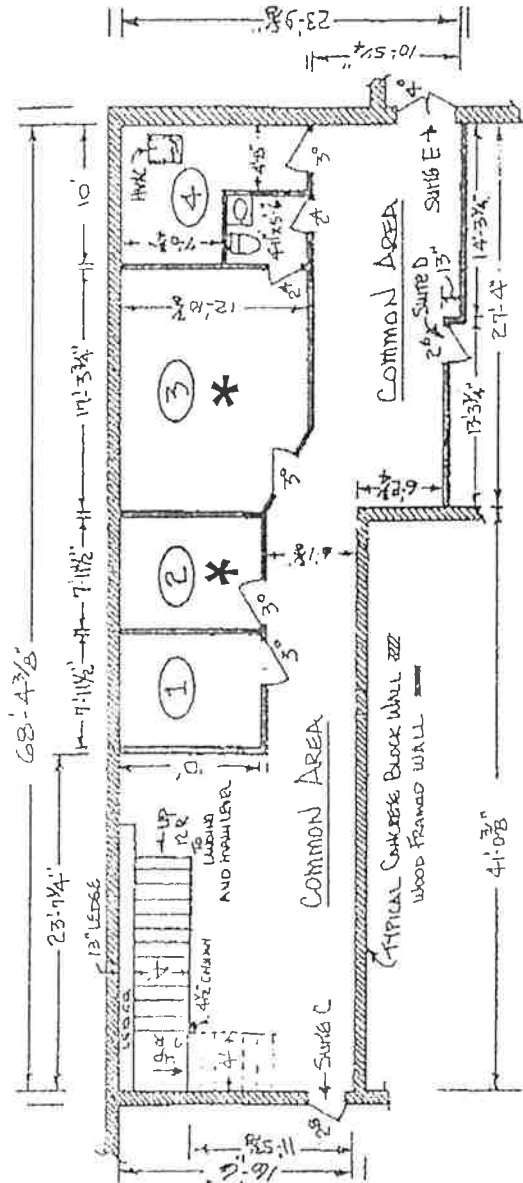
Plot Plan

[illegible]

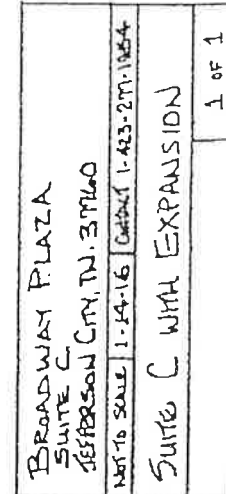
Attachment Section A, Project Details-Item 6 B-2

Floor Plan

300 SF



J. O'H



[illegible]

ALMOST FAMILY

657 BROADWAY
JEFFERSON CITY TN 37760

10:10am

1. **NAME** _____

SCALE _____
SALES _____
DESIGNER _____
DATE _____
REVISION DATES _____

U.S. Patent 6,111,000

January 27, 2017

10:10am

SCALE:
SALES:
DESIGN:
DATE:
REVISION DATES:
SHEET

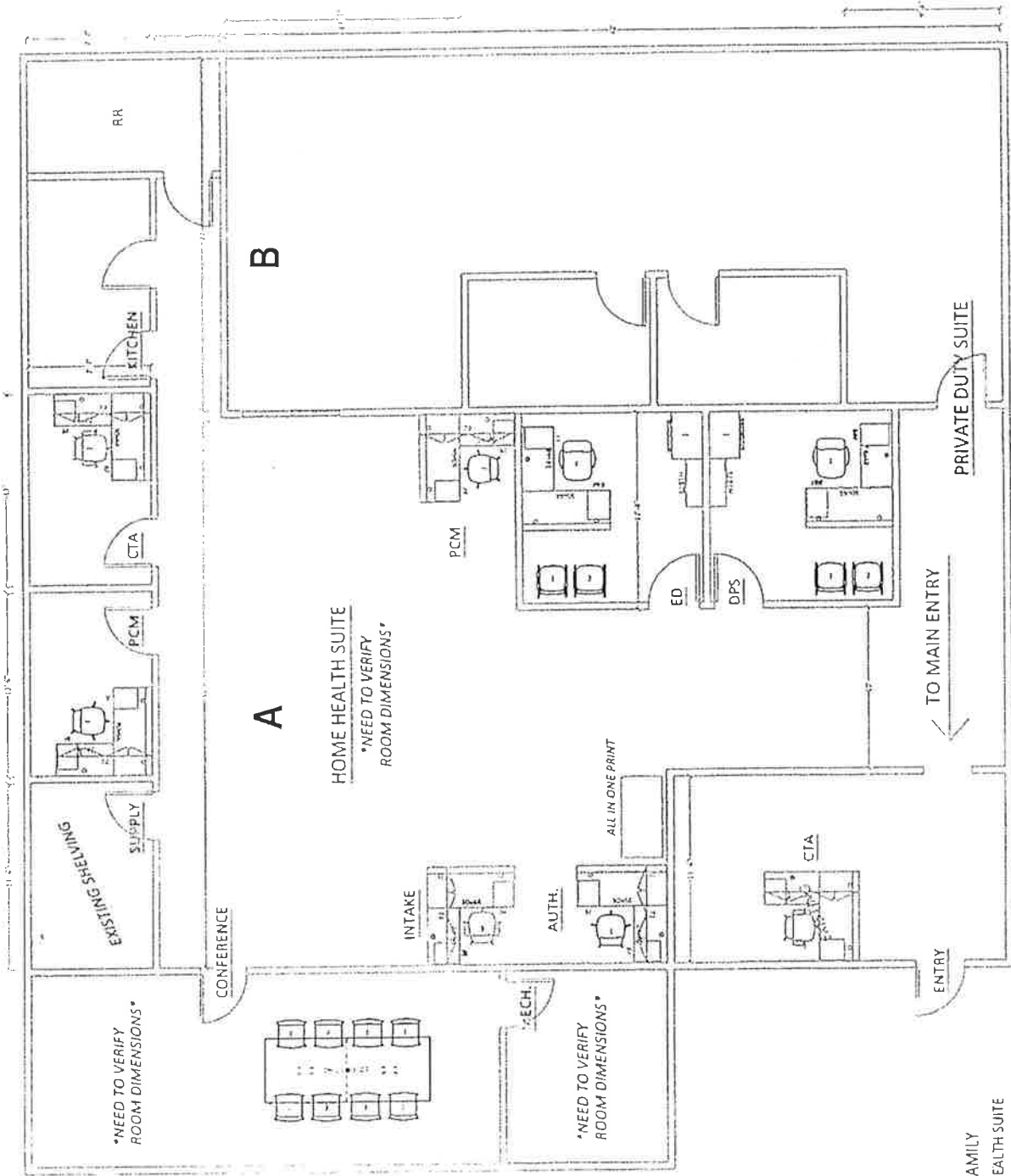
H.H. JEFFERSON CITY, TN

ALMOST FAMILY
HOME HEALTH

657 BROADWAY
JEFFERSON CITY TN 37760

www.OfficeMaxInteriors.com

FURNITURE LAYOUT FOR AREA A



ALMOST FAMILY
AT HOME HEALTH SUITE

Attachment B, Criteria - Need-11
Joint Commission Quality Check Program



SunCrest Healthcare of Middle TN LLC

HCO ID: 571218

1210 Briarville Road, Building D

Madison , TN, 37115-5141

Show Keys +

2013 Safety Goals

Improve the accuracy of patient identification.

Organizations Should

Use of Two Patient Identifiers

Implemented



Improve the safety of using medications.

Organizations Should

Reconciling Medication Information

Implemented



Reduce the risk of health care-associated infections.

Organizations Should

Meeting Hand Hygiene Guidelines

Implemented



Reduce the risk of patient harm resulting from falls.

Organizations Should

Implementing a Fall Reduction Program

Implemented



The organization identifies safety risks inherent in its patient population.

Organizations Should

Identifying Risks Associated with Home Oxygen

Implemented



SunCrest Healthcare of Middle TN LLC
Organization ID: 571218
1210 Briarville Road, Building D Madison, TN 37115-5141

Accreditation Activity - Measure of Success Form

Due Date: 8/31/2016

OME Standard LD.04.01.07 The organization has policies and procedures that guide and support patient care, treatment, or services.

Elements of Performance:

2. The organization manages the implementation of policies and procedures.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%) 90

Month 2 Date: 06/16

Month 2 Actual Goal (%) 91

Month 3 Date: 07/16

Month 3 Actual Goal (%) 92

Month 4 Date: 08/16

Month 4 Actual Goal (%) 90

Actual Average Goal (%) 90

Optional Comments:

OME Standard NPSG.03.06.01 Maintain and communicate accurate patient medication information.

Elements of Performance:

1. Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications.

Note 1: The organization obtains the patient's medication information during the first contact. The information is updated when the patient's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 88

Month 2 Date: 06/16

Month 2 Actual Goal (%): 90

Month 3 Date: 07/16

Month 3 Actual Goal (%): 89

Month 4 Date: 08/16

Month 4 Actual Goal (%): 94

Actual Average Goal (%): 90

Optional Comments:

3. Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 89

Month 2 Date: 06/15

Month 2 Actual Goal (%): 92

Month 3 Date: 07/16

Month 3 Actual Goal (%): 95

Month 4 Date: 08/16

Month 4 Actual Goal (%): 98

Actual Average Goal (%): 93

Optional Comments:

OME Standard NPSG.15.02.01 Identify risks associated with home oxygen therapy such as home fires.

Elements of Performance:

1. Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: - Whether there are smoking materials in the home - Whether or not the home has functioning smoke detectors Note:

Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required. - Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 88

Month 2 Date: 06/16

Month 2 Actual Goal (%): 90

Month 3 Date: 07/16

Month 3 Actual Goal (%): 92

Month 4 Date: 08/16

Month 4 Actual Goal (%): 98

Actual Average Goal (%): 92

Optional Comments:

3. Inform and educate the patient, family, and/or caregiver about the following: - The findings of the safety risk assessment - The causes of fire - Fire risks for neighboring residences and buildings - Precautions that can prevent fire-related injuries - Recommendations to address the specific identified risk(s) Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 90

Month 2 Date: 06/16

Month 2 Actual Goal (%): 95

Month 3 Date: 07/16

Month 3 Actual Goal (%): 93

Month 4 Date: 08/16

Month 4 Actual Goal (%): 92

Actual Average Goal (%): 92

Optional Comments:

4. Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 89

Month 2 Date: 06/16

Month 2 Actual Goal (%): 90

Month 3 Date: 07/16

Month 3 Actual Goal (%): 92

Month 4 Date: 08/16

Month 4 Actual Goal (%): 92

Actual Average Goal (%): 91

Optional Comments:

OME Standard PC.01.02.01 The organization assesses and reassesses its patients.

Elements of Performance:

23. During patient assessments and reassessments, the organization gathers the data and information it requires.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 91

Month 2 Date: 06/16

Month 2 Actual Goal (%): 90

Month 3 Date: 07/16

Month 3 Actual Goal (%): 94

Month 4 Date: 08/16

Month 4 Actual Goal (%): 97

Actual Average Goal (%): 93

Optional Comments:

OME Standard PC.01.03.01 The organization plans the patient's care.

Elements of Performance:

1. The organization plans the patient's care, treatment, or services based on needs identified by the patient's assessment. Note 1: The patient's strengths are considered along with his or her identified needs. Note 2: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 95

Month 2 Date: 06/16

Month 2 Actual Goal (%): 95

Month 3 Date: 07/16

Month 3 Actual Goal (%): 95
 Month 4 Date: 08/16
 Month 4 Actual Goal (%): 98
 Actual Average Goal (%): 96
 Optional Comments:

OME Standard PC.02.01.05 The organization provides interdisciplinary, collaborative care, treatment, or services.

Elements of Performance:

1. All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 90

Month 2 Date: 06/16

Month 2 Actual Goal (%): 90

Month 3 Date: 07/16

Month 3 Actual Goal (%): 92

Month 4 Date: 08/16

Month 4 Actual Goal (%): 90

Actual Average Goal (%): 90

Optional Comments:

8. The organization informs the physician when there is an unanticipated change in the patient's condition or the patient is discharged or transferred.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 92

Month 2 Date: 16/16

Month 2 Actual Goal (%): 95

Month 3 Date: 07/16

Month 3 Actual Goal (%): 94

Month 4 Date: 08/16

Month 4 Actual Goal (%): 96

Actual Average Goal (%): 94

Optional Comments:

OME Standard RC.02.01.01

The patient record contains information that reflects the patient's care, treatment, or services.

Elements of Performance:

2. The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s) - The patient's medical history - Any allergies or sensitivities - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, frequency, and route of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EPs 1 and 23) Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.

Scoring Category: C

Stated Goal (%): 100

Month 1 Date: 05/16

Month 1 Actual Goal (%): 92

Month 2 Date: 06/16

Month 2 Actual Goal (%): 89

Month 3 Date: 07/16

Month 3 Actual Goal (%): 90

Month 4 Date: 08/16

Month 4 Actual Goal (%): 94

Actual Average Goal (%): 91

Optional Comments:

Attachment C, Economic Feasibility - 2-E
Funding Documentation

January 27, 2017**10:10am***Almost Family, Inc.*

9510 Ormsby Station Road, Suite 300
 Louisville, KY 40223
 502.891.1000 Fax: 502.891.8067

January 13, 2017

Tennessee Department of Health Services and Development Agency
 Andrew Jackson Building, 9th Floor
 502m Deaderick Street
 Nashville, TN 37243

RE: Certificate of Need
 Applicant: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
 Lic. #: 0000000093

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health has filed a Certificate of Need Application to move its principal office. The Board of Directors of Tennessee Nursing Services of Morristown have approved the filing of the CON Application, and agreed to provide funding for this application. The funding of this project will come from cash reserves of the company.

Tennessee Nursing Services of Morristown is a fourth tier, wholly owned subsidiary of the public company, Almost Family, Inc. As the ultimate parent company, Almost Family, Inc. also agrees to guarantee all financial obligation of the subsidiary for this CON project.

If you have any questions, please feel free to contact me at (502) 891-1044.

Sincerely,

Patrick Todd Lyles
 Sr. Vice President & Secretary
 Tennessee Nursing Services of Morristown, Inc.

The financial obligations for the Certificate of Need application of Tennessee Nursing Services of Morristown will be guaranteed by the corporate parent.

Almost Family, Inc.

William B. Yarmuth
 Chairman & CEO

Attachment C, Economic Feasibility - 6

Almost Family, Inc. Form 10K

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION**
Washington, D.C. 20549

FORM 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended January 1, 2016

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number 001-09848



ALMOST FAMILY, INC.

(Exact name of Registrant as specified in its charter)

Delaware

(State or other jurisdiction of incorporation or organization)

06-1153720

(I.R.S. Employer Identification Number)

9510 Ormsby Station Road, Suite 300, Louisville, Kentucky 40223
(Address of principal executive offices)

(502) 891-1000

(Registrant's telephone number, including area code)

Not Applicable

(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act

Title of each class
Common Stock, par value \$0.10 per share

Name of each exchange on which registered
NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐

Accelerated filer ☒

Non-accelerated filer ☐

Smaller reporting company ☐

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant as of the last day of the second fiscal quarter ended July 3, 2015 was \$334,169,264 based on the last sale price of a share of the common stock as of July 2, 2015 (\$39.21), as reported by the NASDAQ Global Market.

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

Class
Common Stock, \$0.10 par value per share

Outstanding at March 2, 2016
10,299,575 Shares

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the 2016 definitive proxy statement relating to the registrant's Annual Meeting of Stockholders are incorporated by reference in Part III to the extent described therein.

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEET S
(In thousands)

	January 1, 2016	December 31, 2014
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	\$ 7,522	\$ 6,886
Accounts receivable - net	92,270	74,602
Prepaid expenses and other current assets	9,672	10,420
TOTAL CURRENT ASSETS	109,464	91,908
PROPERTY AND EQUIPMENT - NET	10,000	5,575
GOODWILL	277,061	192,523
OTHER INTANGIBLE ASSETS	64,629	54,402
OTHER ASSETS	3,615	850
TOTAL ASSETS	\$ 464,769	\$ 345,258
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Accounts payable	\$ 12,297	\$ 9,257
Accrued other liabilities	42,524	42,326
Current portion - notes payable and capital leases	—	51
TOTAL CURRENT LIABILITIES	54,821	51,634
LONG-TERM LIABILITIES:		
Revolving credit facility	113,790	46,447
Deferred tax liabilities	13,094	11,280
Seller notes	6,556	1,500
Other liabilities	2,608	1,205
TOTAL LONG-TERM LIABILITIES	136,048	60,432
TOTAL LIABILITIES	190,869	112,066
NONCONTROLLING INTEREST - REDEEMABLE - HEALTHCARE INNOVATIONS	3,639	3,639
STOCKHOLDERS' EQUITY:		
Preferred stock, par value \$0.05; authorized 2,000 shares; none issued or outstanding	—	—
Common stock, par value \$0.10; authorized 25,000; 10,125 and 9,574 issued and outstanding	1,013	957
Treasury stock, at cost, 103 and 94 shares	(2,731)	(2,392)
Additional paid-in capital	127,253	105,862
Noncontrolling interest - nonredeemable	(730)	(420)
Retained earnings	145,456	125,546
TOTAL STOCKHOLDERS' EQUITY	270,261	229,553
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	\$ 464,769	\$ 345,258

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands)

	Common Stock		Treasury Stock		Additional	Retained	Non-	Total	Non-
	Shares	Amount	Shares	Amount	Paid-in Capital	Earnings	controlling Interest - Non-redeemable	Stockholders' Equity	controlling Interest - Redeemable
Balance, December 31, 2012	9,421	\$ 942	(91)	\$ (2,320)	\$ 101,945	\$ 103,748	\$ —	\$ 204,315	\$ —
Stock award maturities, net of shares surrendered or withheld	1	1	(1)	(20)	17	—	—	(2)	—
Share awards and related compensation	52	5	—	—	1,460	—	—	1,465	—
Tax loss from stock-based compensation	—	—	—	—	(62)	—	—	(62)	—
Stock provided in acquisitions	26	2	—	—	498	—	—	500	—
Acquired noncontrolling interest	—	—	—	—	0	—	(193)	(193)	3,639
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	(185)
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(185)	—	(185)	185
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	7	7	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	8,226	—	8,226	—
Balance, December 31, 2013	9,500	\$ 950	(92)	\$ (2,340)	\$ 103,358	\$ 111,789	\$ (186)	\$ 214,071	\$ 3,639
Stock award maturities, net of shares surrendered or withheld	14	1	(2)	(52)	156	—	—	105	—
Share awards and related compensation	60	6	—	—	1,808	—	—	1,814	—
Tax gain from stock-based compensation	—	—	—	—	40	—	—	40	—
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	(6)
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(6)	—	(6)	6
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	(234)	(234)	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	13,763	—	13,763	—
Balance, December 31, 2014	9,574	\$ 957	(94)	\$ (2,392)	\$ 105,862	\$ 125,546	\$ (420)	\$ 229,553	\$ 3,639
Stock award maturities, net of shares surrendered or withheld	10	1	(9)	(339)	128	—	—	(210)	—
Share awards and related compensation	100	11	—	—	2,110	—	—	2,121	—
Tax gain from stock-based compensation	—	—	—	—	215	—	—	215	—
Stock provided in acquisitions	441	44	—	—	18,938	—	—	18,982	(99)
Net loss noncontrolling interests - redeemable	—	—	—	—	—	—	—	—	99
Noncontrolling interests - redeemable fair value accretion	—	—	—	—	—	(99)	—	(99)	—
Net loss noncontrolling interests - nonredeemable	—	—	—	—	—	—	(310)	(310)	—
Net income attributable to Almost Family, Inc.	—	—	—	—	—	20,009	—	20,009	—
Balance, January 1, 2016	10,125	\$ 1,013	(103)	\$ (2,731)	\$ 127,253	\$ 145,456	\$ (730)	\$ 270,261	\$ 3,639

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

ALMOST FAMILY, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOW S
(in thousands)

	Fiscal Year ended		
	January 1, 2016	December 31, 2014	December 31, 2013
Cash flows from operating activities:			
Net income	\$ 19,541	\$ 13,524	\$ 8,048
Loss on discontinued operations, net of tax	—	—	(558)
Net income from continuing operations	19,541	13,524	8,606
Adjustments to reconcile income to net cash provided by operating activities:			
Depreciation and amortization	4,208	4,103	2,862
Provision for uncollectible accounts	12,743	9,417	5,378
Stock-based compensation	2,121	1,814	1,465
Deferred income taxes	3,914	5,500	2,099
	42,527	34,358	20,410
Change in certain net assets and liabilities, net of the effects of acquisitions:			
(Increase) decrease in:			
Accounts receivable	(17,393)	(25,613)	(4,440)
Prepaid expenses and other current assets	2,402	(647)	4,229
Other assets	(585)	165	235
Accounts payable and accrued expenses	(5,745)	(1,277)	(888)
Net cash provided by operating activities	21,206	6,986	19,546
Cash flows from investing activities:			
Capital expenditures	(3,117)	(1,231)	(2,502)
Cost basis investment	(1,000)	—	—
Acquisitions, net of cash acquired	(82,578)	(969)	(88,465)
Net cash used in investing activities	(86,695)	(2,200)	(90,967)
Cash flows from financing activities:			
Credit facility borrowings	233,425	66,632	56,000
Credit facility repayments	(166,082)	(76,185)	—
Debt issuance fees	(1,161)	—	—
Proceeds from stock option exercises	128	156	11
Purchase of common stock in connection with share awards	(338)	(52)	(20)
Tax impact of share awards	215	40	(62)
Payment of special dividend	(50)	(35)	—
Principal payments on notes payable and capital leases	(12)	(702)	(720)
Net cash provided by (used in) financing activities	66,125	(10,146)	55,209
Cash flows from discontinued operations:			
Operating activities	—	—	(742)
Investing activities	—	—	3,080
Net cash from discontinued operations	—	—	2,338
Net change in cash and cash equivalents	636	(5,360)	(13,874)
Cash and cash equivalents at beginning of period	6,886	12,246	26,120
Cash and cash equivalents at end of period	\$ 7,522	\$ 6,886	\$ 12,246
Supplemental disclosures of cash flow information:			
Cash payment of interest, net of amounts capitalized	\$ 1,890	\$ 1,264	\$ 97
Cash payment of taxes	\$ 4,651	\$ 1,953	\$ 6,084
Summary of non-cash investing and financing activities:			
Acquisitions funded by notes payable	\$ 5,000	\$ —	\$ 1,500
Acquisitions funded by stock	\$ 18,982	\$ —	\$ 500

The accompanying notes to consolidated financial statements are an integral part of these financial statements.

DEC 15 '16 PM

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

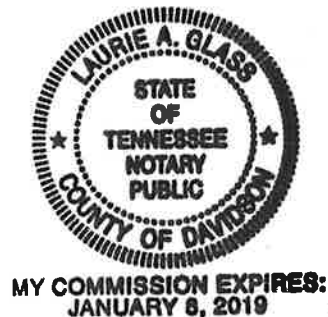
Kim H. Looney, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.


SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of December, 2016, a Notary Public in and for the County/State of Tennessee.


NOTARY PUBLIC

My commission expires January 8, 2019.



Supplemental- #1 -Original-

Tennessee Nursing
Services of Morristown

CN1612-042

January 27, 2017

10:10am

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 27, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc.
CN1612-042

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated December 21, 2016, wherein additional information or clarification was requested regarding the above-referenced CON application.

1. Section A., Applicant Profile, Item A.1. Facility Address

The applicant provided the address of the current location. Please provide the address of the proposed new location and submit a replacement page.

Response: The proposed new location is 657 Broadway, Suite C, Jefferson City (Jefferson County), Tennessee 37760-4949 (see also replacement page 1 included as Attachment Section A, Applicant Profile-A-1).

2. Section A., Executive Summary A, Item A

Please clarify if the applicant will be surrendering the CON specific to the 409 Cawood Road, Tazewell, TN location.

Response: The applicant is relocating its principal office for the existing services to the 657 Broadway, Suite C, Jefferson City, TN branch office location. It will no longer operate an office at 409 Cawood Road in Tazewell for home health services. (When the home health agency was licensed, the CON merged into the license). Additionally, the Jefferson City location is close to a major highway, whereas Tazewell is not centrally located. Because Jefferson City is currently a branch office and Tazewell is the parent office of the home health agency, both can

January 27, 2017**10:10am****waller**

Phillip M. Earhart
HSDA Examiner
January 27, 2017
Page 2

and access to service will not change or be negatively affected with the approval of this project.

3. Section A., Executive Summary A, Item C, Consent Calendar Justification

The Consent Calendar Justification letter could not be found. If applicable, please briefly specify the reasons for requesting Consent Calendar by addressing each of the four criteria: 1) Need, 2) Economic Feasibility, and 3) Contribution to the Orderly Development of Health Care, and 4) Quality Measures.

Response: The request to be placed on the consent calendar was filed the same day as the application. An updated Consent Calendar Justification letter filed on January 26, 2017, is included as Attachment A, Executive Summary-Item C.

4. Section A, Project Details, Item 4 B. (1) Plot Plan

As required for all projects, a Plot Plan must provide the size of the site (in acres), location of the structure on the site, the location of the proposed construction, and the names of streets, roads, highways that cross or border the site. Please provide a new Plot Plan with all the required information.

Response: Please see plot plan included as Attachment Section A, Project Details, Item 4-B.1. The applicant currently operates a branch office at the proposed location. As shown on the attached plot plan, the existing building in Broadway Plaza is on plot number 82.02, which consists of 2.34 acres. The applicant is currently located in Suite C and will continue to be located in this same suite upon relocating its principal office into the existing branch office space. The building borders U.S. Highway 11E. The applicant occupies 4,123 square feet.

A question came up verbally about whether or not the applicant had discontinued using the space in Jefferson City as its principal office. (Please recall from the application that the applicant applied for and received all approvals were granted necessary to effect this change, including a new license. It was only after these approvals that it received notification that it should have applied for and received CON approval prior to the change taking place.) The applicant currently is using the Jefferson City location as a branch office and the location at 409 Cawood Road in Tazewell is being operated as the principal office. Upon approval of this application, the applicant will operate the proposed location as the principal office and the location in Tazewell will no longer be used for home health services.

5. Section A, Project Details, Item 4 B. (2) Floor Plan

Please provide a floor plan as referenced in Attachment 6B-2.

waller

Phillip M. Earhart
HSDA Examiner
January 27, 2017
Page 3

Response: Please see floor plan included as Attachment Section A, Project Details, Item 6B-2. The applicant currently leases 4,123 square feet of space. The floor plan is in several drawings that have the square footage identified. Two of the drawings show furniture location in the leased office space. All of the space is office and conference room space; none of the areas is used for patient care.

6. Section B, Need, Item 2.a. and 2.b (Project Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions)

Please address #2.a and #2.b. of the Project Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions.

Response: Please see response below.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. For relocation or replacement of an existing licensed health care institution:

- a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Response: In this situation, the applicant does not need to renovate its existing space, and there would be no benefits provided if it did. It has determined that relocating the principal office will allow services to be provided more efficiently as well as result in a cost savings. Instead of having 3 locations to provide the necessary home health services, with 2 being branch offices and one being the principal office, the applicant will have 1 branch office and one principal office as a result of the approval of this application. This consolidation makes sense, both from a health planning perspective as well as efficiency and cost savings perspectives.

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response: The applicant is an existing licensed home health agency. The relocation of its principal office should have no significant effect on the demand for its services; as an operating home health agency, the demand already exists.

7. Section B, Need, Item 4A. (Proposed Service Area)

It appears the Projected Population Year in the population table on page 20 of the application is 2020. However, it is unclear what year is designated for the current year. Please use the year 2016 for the current year and revise the table if necessary.

January 27, 2017**10:10am****waller**

Phillip M. Earhart
HSDA Examiner
January 27, 2017
Page 4

Response: The table has been revised to account for 2016 projected population data from the Department of Health/Health Statistics. See revised page 20 included as Attachment Section B, Need-Item 4A.

8. Section B, Need, Item 6.

Please respond to item 6 on page 21. This question is required for all projects.

Response: The utilization for each of the past 3 years, as provided on the Historical Data Chart is included below, along with an estimate for projected utilization for 2017 and 2018. The applicant applied a conservative growth rate of 3%.

Number of Visits

2014	29,323
2015	28,316
2016	29,806
2017	30,700
2018	31,621

9. Section B, Economic Feasibility, Item 1.

It is noted the applicant already operates the office proposed as the principal office as a branch office. However, in Section B of the Project Costs Chart, please designate the fair market value of the space assigned to the applicant's proposed new home health business location or the total amount of lease payments over the initial term of the lease, whichever is greater.

Response: The applicant has included the assessed value of the entire leased space on the revised Project Costs Chart. The assessed value of 4,123 square feet leased by the applicant has been multiplied by the value of \$59.77 per square foot for a cost of \$246,432. Please see replacement page 23, Project Costs Chart, and the record from the tax assessor's office which shows the value of the building and land, included as Attachment Section B, Economic Feasibility, Item 1.

10. Section B, Economic Feasibility, Item 2. Funding

It is noted the proposed project will be funded through cash reserves. However the funding documentation from the applicant's Vice President and Secretary does not state the proposed project will be funded with cash reserves. Please revise.

Response: Please see revised letter that has been executed by both Todd Lyles, Sr. Vice President and Secretary for Tennessee Nursing Services of Morristown, Inc., and William Yarmuth, Chairman and CEO of Almost Family, Inc., its parent company included as Attachment Section B, Economic Feasibility-Item 2.

waller

Phillip M. Earhart
 HSDA Examiner
 January 27, 2017
 Page 5

11. Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

Please complete a Historical and Projected Data Chart for the proposed project.

Response: The Historical Data Chart on pages 25 and 26 and Projected Data Chart on pages 28 and 29 are included as Attachment Section B, Economic Feasibility-4-Q.11.

12. Section B. Economic Feasibility Item 5.A

Please complete the table for Gross Charge, Deductions from Revenue, and Average Net Charge (use figures from the Historical and Projected Data Charts).

Response: Please see revised page 30 to include completion of table for Gross Charge, Deductions from Revenue and Average Net Charge, based on the Historical and Projected Data Charts, included as Attachment Section B, Economic Feasibility-Item 5.A. The average net charge for 2015 compares favorably with that of similar facilities in the service area, and is the median of the charges compared.

13. Section B. Economic Feasibility Item 6.B and 6.C.

Please provide a response to 6 (B.) (Net Operating Margin Ratio) and 6 (C) (Capitalization Ratio).

Response: Please see revised page 31 included as Attachment Section B, Economic Feasibility-Item 6.B and 6.C. which includes the completed net operating margin ratio table. There is no capitalization ratio.

14. Section B. Economic Feasibility Item 7.

The payor mix table is noted. Please complete by using the applicant's Projected Data Chart Year One figures and submit.

Response: Please see revised page 32, included as Attachment Section B, Economic Feasibility-Item 7.

15. Section B. Economic Feasibility Item 8 A. and 8. B.

The staffing tables on page 33 of the application are noted. However, please complete the columns for "Average Wage (Contractual Rate)" and "Area Wide/Statewide Average Wage" and submit.

waller

Phillip M. Earhart
HSDA Examiner
January 27, 2017
Page 6

JAN 27 '17 AM 10:09

Response: Please see revised page 33 included as Attachment Section B, Economic Feasibility-Item 8A and 8B.

16. Section B. Orderly Development Item 1.

List all existing health care provider (i.e. hospitals, using homes, home care organizations etc.) managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements, contractual agreements for health services.

Response: The applicant has relationships with many area hospitals, nursing homes, assisted living facilities and physicians. Included below are some of those relationships:

Asbury Place at Steadman Hill
Bristol Regional Medical Center
Broadmore Senior Living
Brookdale Assisted Living
Brookdale Senior Living
Elmcroft of Kingsport
Hancock County Hospital
Jefferson County Nursing Home
Lafollette Court Assisted Living Center
Laughlin Memorial Hospital
Laurel Manor Health Care
Life Care Center
Morristown Hamblen Hospital
NHC Healthcare
Signature Healthcare
Tennova Jefferson Memorial Hospital
Tennova Lafollette Medical Center
The Cambridge House
The Village at Allandale
Wexford House

17. Section B. Orderly Development Item 4.

Please provide documentation of Joint Commission accreditation.

Response: Please see copy of Joint Commission accreditation letter included as Attachment Section B, Orderly Development-Item 4.

waller

January 27, 2017**10:10am**

Phillip M. Earhart
HSDA Examiner
January 27, 2017
Page 7

18. Section B. Orderly Development Item 4B. and 4C.

It is noted there were no deficiencies as a result of the most recent survey. Please provide a letter from the appropriate agency documenting there were no deficiencies.

Response: Please see letter from Karen Kirby, Regional Administrator, of the Office of Licensure and Regulation, East Tennessee Region noting no deficiencies were found after a recertification survey included as Attachment Section B, Contribution to the Orderly Development of Healthcare, Item 4B and 4C-Q.18.

Section B. Orderly Development, Project Completion Forecast Chart.

Please complete the Project Completion Forecast Chart

Response: Please see revised page 41 - Project Completion Forecast Chart included as Attachment Section B, Contribution to the Orderly Development of Healthcare-Q19.

Please contact me if you have any questions or need additional information.

Sincerely,



Kim Harvey Looney

KHL:lag

Attachments

Attachment Section A, Executive Summary-Item C

Consent Calendar Justification Letter

waller

990
JAN 26 '17 AM 10:10

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966
January 27, 2017
615.244.6800 main
615.244.6804 fax
wallerlaw.com
10:10am

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 26, 2017

VIA HAND DELIVERY

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health
CN1612-042

Dear Melanie:

Please be advised that the applicant requests that the application be placed on the consent calendar. The applicant would expect no opposition to this project since it is not adding any counties to its service area. The applicant does not expect that the proposed relocation of its principal office would affect the criteria of need or quality measures as the applicant intends to continue to operate in the same service area, offering the same high quality level of services following the relocation. The criteria of economic feasibility could be affected by this proposed relocation insofar as the relocation will allow the applicant to reduce overhead by cutting back on administrative and leasing costs. Furthermore, a positive effect may occur with respect to the orderly development of health care in that the proposed relocation will place the principal office of the project in Jefferson County, the county with the highest projected population growth from 2016 to 2020.

If you have any questions or need any additional information, please do not hesitate to call me.

Sincerely,



Kim Harvey Looney

KHL:lag

Property Type: 08 Commercial

[illegible]

January 27, 2017

10:10am

ASSESSOR OF PROPERTY - PROPERTY RECORD CARD

Property Type: 08 Commercial

Date	Book	Page	Price	Sales Tax Price %	Acres	A/R	Owner
03/30/2016	1255	655	890,000	QC	QC	P	KOUSER FAMILY LIMITED PARTNERSHIP
04/14/2014	1236	175	890,000	WD	WD	E	KOUSER ACQUEL & HINA
10/28/2007	804	331		QC	QC	E	CROWN HILL ENTERPRISES LLC
02/18/1998	321	37					HAYES H DAVID & SHARON

Property Address		Subdivision		LOT B		TRACT		TAX YEAR 2017		C		G		Parcel #		S#	
Ownership and Mailing Address		BK M 88	PG 280	BLOCK	LOT B	TRACT	JEFFERSON	City	Map	Dist	Card: 1 of 1	Page: 2 of 2	Updated	Printed	10/21/2016	01/13/2017	
KOUSER FAMILY LIMITED PARTNERSHIP #1 P O BOX 1203 TALBOTT TN 37877		BK	PG	BLOCK	LOT	TRACT	SSD1	43385 Jefferson City	Map 0180	Dist 04	Card: 1 of 1	Page: 2 of 2	Updated	Printed	10/21/2016	01/13/2017	
		Additional Description		INCLUDES COMMON GROUND BLDG B; 857 & 873				Total Land Under Deed Acres	5300	0	Calculated Acres	0					
		Dimensions		212.1 X 153.9 IRR 106.7 X 49.7													

NOTES:

BOB GOLE LAW OFFICE- 669) NAIL PLACE - 875; TN BOARD OF PROBATION A PAROLE - REA L ESTATE REFERRAL SERVICES(677); WARNER CHORPRACTIC 673; LAND IS SF PRICED

January 27, 2017**10:10am**

**Attachment Section B, Contribution to the Orderly
Development Of Health Care**

Regional Administrator, Office of Licensure Letter

January 27, 2017

10:10am



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
7175 STRAWBERRY PLAINS PIKE, SUITE 103
KNOXVILLE, TENNESSEE 37914-7008

November 16, 2015

Ms. Christy West, Administrator
Suncrest Home Health
409 Cawood Lane
Tazewell, TN 37879

Re: CMS Certification Number #44-7528

Dear Ms. West:

The East Tennessee Regional Office conducted a recertification survey and a complaint investigation at your facility on November 3 - 5, 2015. As a result of the survey, no deficient practice was found.

If you have any questions, please call our office at (865) 594-9396.

Sincerely,

A handwritten signature in dark ink, reading "Karen B. Kirby" followed by a stylized flourish.

Karen B. Kirby, R.N.
Regional Administrator
East TN Health

KBK:cvb

TN00036163

January 27, 2017

10:10am

PRINTED: 11/09/2015

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 447528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER SUNCREST HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 409 CAWOOD LANE TAZEWELL, TN 37879		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS A recertification and complaint investigation (#36163) survey were completed at Suncrest Home Health from 11/3/15 through 11/5/15. No deficiencies were cited under CFR Part 484, Requirements for Home Care Organizations Providing Home Health Services.	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

January 27, 2017

10:10am

PRINTED: 11/09/2015
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNH177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER SUNCREST HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 409 CAWOOD LANE TAZEWELL, TN 37879		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-26 Initial. A Licensure and complaint investigation (#36163) survey were completed at Suncrest Home Health from 11/3/15 through 11/5/15. No deficiencies were cited under Chapter 1200-08-26 Standards for Home Care Organizations Providing Home Health Services.	H 001		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

January 27, 2017

10:10am

JAN 27 '17 AM 10:10

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.
CN1612-042

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.


Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27th day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.


NOTARY PUBLIC

My commission expires: January 8, 2019.

HF-0043

Revised 7/02



Supplemental- #2 -COPY-

Tennessee Nursing
Services of Morristown

CN1612-042

January 31, 2017

10:18 am

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

January 31, 2017

VIA HAND DELIVERY

Phillip M. Earhart
HSDA Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building
9th Floor
502 Deaderick Street
Nashville TN 37243

Re: Tennessee Nursing Services of Morristown, Inc.
CN1612-042
Second Supplemental Request

Dear Phillip:

This letter is submitted as the supplemental response to your letter dated January 30, 2017, wherein additional information or clarification was requested regarding the above-referenced CON application.

1. Section B. Economic Feasibility Item 4. (Historical Data Chart and Projected Data Chart)

The Historical and Projected Data Charts for the proposed project are noted. However, please complete Section G. for the submitted Historical and Projected Data Charts.

Response: Please see revised pages R-26 and R-29 for the Historical and Projected Data Charts included as Attachment Section B, Economic Feasibility, Item 4.

2. Section B. Economic Feasibility Item 6.B and 6.C.

Please provide a response to 6 (C) (Capitalization Ratio). The capitalization ratio is required for all projects.

Response: The long-term debt (in thousands) is \$171,153, with net assets of \$521,132 (in thousands) for a capitalization ratio of 32.8% for Almost Family, the parent company of the applicant, based on the 10Q for the period ending September 30, 2016.

January 31, 2017

10:18 am

Phillip M. Earhart
HSDA Examiner
January 31, 2017
Page 2

Please contact me if you have any questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim", with a stylized flourish at the end.

Kim Harvey Looney

KHL:lag

Attachments

January 31, 2017

10:18 am

JAN 31 11:17 AM

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: TENNESSEE NURSING SERVICES OF MORRISTOWN, INC.
CN1612-042

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney
Signature/Title

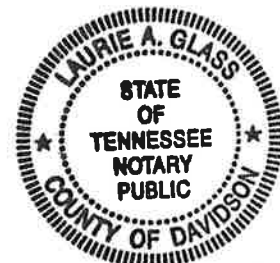
Sworn to and subscribed before me, a Notary Public, this the 31st day of January, 2017, witness my hand at office in the County of Davidson, State of Tennessee.

Laurie A. Glass
NOTARY PUBLIC

My commission expires: January 8, 2019.

HF-0043

Revised 7/02



MY COMMISSION EXPIRES:
JANUARY 8, 2019



State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

DEC 9 '16 AM 11:22

LETTER OF INTENT

The Publication of Intent is to be published in the

The Greeneville Sun (Greene); The
Rogersville Review (Hawkins and
Hancock); Kingsport Times News
(Sullivan); Knoxville News Sentinel
(Claiborne, Campbell, Cocke,
Grainger, Hamblen, Jefferson and
Union counties)

which are newspapers

(Name of Newspaper)

of general circulation in

Campbell, Claiborne, Cocke,
Grainger, Greene, Hamblen,
Hancock, Hawkins,
Jefferson, Sullivan and Union
counties,

(County)

Tennessee, on or before

December 10, 20 16
(Month/Day) (Year)

for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health

home health agency

(Name of Applicant)

(Facility Type-Existing)

owned by: SunCrest Home Health of Claiborne County, Inc. with an ownership type of

corporation

and to be managed by: itself intends to file an application for a Certificate of Need

for : relocation of its principal office from 409 Cawood Road, Tazewell, Tennessee 37879-3026 (Claiborne County), to its

Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee 37760-4949. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan and Union counties and will remain the same following relocation. The costs of the project are expected to be approximately \$100,000.

The anticipated date of filing the application is:

December 15, 20 16

The contact person for this project is

Kim H. Looney, Esq.

Attorney

(Contact Name)

(Title)

who may be reached at:

Waller Lansden Dortch & Davis LLP

511 Union Street, Suite 2700

(Company Name)

(Address)

Nashville

TN

37219

615

/

850-8722

(State)

(Zip Code)

(Area Code)

(Phone Number)

December 9, 2016

Kim.Looney@wallerlaw.com

(Signature)

(Date)

(Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

**RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY**

**CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA**

TABLE OF CONTENTS

0720-11-.01 General Criteria for Certificate of Need

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

- (1) Need. The health care needed in the area to be served may be evaluated upon the following factors:
 - (a) The relationship of the proposal to any existing applicable plans;
 - (b) The population served by the proposal;
 - (c) The existing or certified services or institutions in the area;
 - (d) The reasonableness of the service area;
 - (e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
 - (f) Comparison of utilization/occupancy trends and services offered by other area providers;
 - (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.
- (2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:
 - (a) Whether adequate funds are available to the applicant to complete the project;
 - (b) The reasonableness of the proposed project costs;
 - (c) Anticipated revenue from the proposed project and the impact on existing patient charges;
 - (d) Participation in state/federal revenue programs;
 - (e) Alternatives considered; and
 - (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.
- (3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(Rule 0720-11-.01, continued)

- (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);
 - (b) The positive or negative effects attributed to duplication or competition;
 - (c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;
 - (d) The quality of the proposed project in relation to applicable governmental or professional standards.
- (4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:
 - (a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.
 - (b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.
 - (c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.
- (5) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: T.C.A. §§ 4-5-202, 68-11-1605, and 68-11-1609. **Administrative History:** Original rule filed August 31, 2005; effective November 14, 2005.

**CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954**

DATE: March, 31 2017

APPLICANT: Tennessee Nursing Services of Morristown, Inc.
d/b/a SunCrest home Health
657 Broadway, Suite C
Jefferson City, Tennessee 37760

CONTACT PERSON: Kim Looney
511 Union Street, Suite 2700
Nashville, Tennessee 37219

COST: \$100,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

Tennessee Nursing Services of Morristown, Inc. d/b/a SunCrest Home Health seeks Certificate of Need (CON) approval for the relocation of its principal office from 409 Cawwood Road, Tazewell, (Claiborne County) Tennessee to its Jefferson County office located at 657 Broadway, Suite C, Jefferson City, Tennessee. The existing service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan, and Union counties and will remain the same following relocation.

The total estimate cost of the project is \$306,432 and will be funded through cash reserves.

This application has been placed on the Consent Calendar. Tenn. Code Ann. § 68-11-1608 Section (d) states the executive director of Health Services and Development Agency may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan*.

NEED:

The applicant's service area consists of Campbell, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Sullivan, and Union counties.

2017-2021 Service Area Total Population Projections

County	2017	2021	% Increase or Decrease
Campbell	41,559	41,839	0.7%
Claiborne	34,038	34,917	2.6%

Cocke	37,163	37,815	1.8%
Grainger	24,073	24,727	2.7%
Greene	73,075	75,163	2.9%
Hamblen	65,774	67,429	2.5%
Hancock	6,970	7,021	0.7%
Hawkins	59,043	60,002	1.6%
Jefferson	56,406	59,005	4.6%
Sullivan	159,191	159,906	0.4%
Union	20,020	20,412	2.0%
Total	577,312	588,236	1.9%

Tennessee Population Projections 2015 Revised UTCBER, Tennessee Department

The applicant is an established home health agency licensed in 11 counties in the northeastern portion of Tennessee. On January 29, 2016, the applicant sent a letter to the Department of Health, Board for Licensing Health Care Facilities notifying the Board they were relocating the principal office for its home health agency from Tazewell to Johnson City, TN. as well as consolidating its operations to Johnson City, which it had previously operated as a branch office of the agency, effective March 1, 2016. The applicant also stated they would be notifying CMS to delete the Johnson City Branch designation and to relocate the principal office to this location. The applicant received a letter on June 21, 2016 acknowledging the changes from the Board for Licensing Health Care Facilities, along with a new license with the address change.

Additionally, the applicant sent a notice to Palmetto GBA, its fiscal intermediary for Medicare, along with the appropriate CMS855A forms to effect the change described above. The applicant was not aware that approval was required from HSDA prior to seeking a new Tennessee State license with the address change and an approval letter from CMS. Furthermore, the applicant did not know they needed to file a CON to relocate until they received a letter from Licensure that they need approval from HSDA first.

Need

The applicant is seeking to consolidate some of its operations in order to reduce administrative costs. This project accomplishes that through a reduction in administrative staff and the closure of one office, for a reduction in costs of \$87,000 per year. Also, the relocation will place the principle office in a geographic location that is more centrally located within the service area.

Economic Feasibility

The costs are only those that are associated with the application itself and include legal fees and HSDA filing fee. The applicant will realize an annual savings of \$87,000.

Appropriate Quality Standards

The applicant provides high quality service as evidenced by the Quality Report from The Joint Commission and the lack of deficiencies in the last licensure survey.

Orderly Development to adequate and effective health care.

Not applicable.

TENNCARE/MEDICARE ACCESS:

The applicant participates in the Medicare and Medicaid/TennCare programs. The applicant has contracts with TennCare MCOs AmeriGroup, United Healthcare Community Plan, BlueCare and TennCare Select.

The applicant projects year one Medicare revenues of \$4,973,270.59 or 93.59% of total gross revenues and TennCare revenues of \$124,876 or 2.35% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:

The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of

utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located in Supplemental 1. The total estimated project cost is \$306,432.

Historical Data Chart: The Historical Data Chart is located Supplemental 1. The applicant reported 29,323, 28,316, and 29,806 visits in 2014, 2015, and 2016 with net operating revenues of (\$71,403), \$264,900 and \$202,660 each year, respectively.

Projected Data Chart: The Projected Data Chart is located in Supplemental 1. The applicant projected 30,700 and 31,621 visits in years one and two with net operating revenues of \$356,994 and \$383,212 each year, respectively.

Proposed Charge Schedule

	Previous Year	Current Year	Year One	Year Two	% Change
Gross Charge	\$167.58	173.09	\$173.09	\$173.09	0
Average Deduction	\$29.80	\$25.02	\$27.34	\$27.34	0
Average Net Charge	\$137.78	\$148.07	\$145.75	\$145.75	0

Staffing

Title	FTE
RN	4.8
LPN	3.0
CNA	0
Physical Therapist	7.6
Occupational Therapist	2.6
Speech/Language/Pathology	1.0
Medical Social Services	1.0
Respiratory Therapists	0
Home Health Aide	3.2
Homemakers	0
Nutritionists/Dietitians	0
Administrator	1.0
Clinical director/In-office Staff	7.0
Office Personnel	3.0
Other Administrative Staff	3.0
Total	37.2

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

The applicant is an existing home health agency with established relationships.

The applicant sees no positive or negative effect on the competition as this is merely the relocation of a principle office.

The applicant is an existing home health agency and meets the staffing requirements for licensure.

QUALITY MEASURES

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Health Care Facilities and accredited by The Joint Commission.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan*.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

N/A

2. For relocation or replacement of an existing licensed health care institution:

- a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

The applicant did not need to renovate its existing space and there would be no benefits if it did. It was determined that relocating the principal office would allow services to be provided more efficiently as well as result in a cost savings.

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The applicant is an existing home health agency. The relocation of the principal office should have no significant effect on the demand for its services; as an operating home health agency, the demand already exists.

3. For renovation or expansions of an existing licensed health care institution:

- a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

N/A

- b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

N/A